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S 000	Initial Comments Complaint Survey: 2471939/IL170710	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)2 300.1210d)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	S9999		

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

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:

2) All treatments and procedures shall be administered as ordered by the physician.

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 observation, interview, and record review, the facility failed to ensure a resident with a history of falls was provided hourly rounding as ordered by the physician and failed to implement new, individualized fall risk interventions for residents who experienced falls, to prevent further falls.

This failure resulted in R1 experiencing an unwitnessed fall at the facility and sustaining a subdural hematoma and R2 falling and sustaining a laceration requiring closure with sutures.

This applies to 3 of 3 residents (R1, R2, and R3) reviewed for resident injury in the sample of 4.

The findings include:

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1. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on February 1, 2024. The EMR continues to show R1 was sent to the local hospital on March 6, 2024 at 6:50 AM due to abdominal distention and did not return to the facility. R1 had multiple diagnoses including, bipolar type schizoaffective disorder, COPD (Chronic Obstructive Pulmonary Disease), insomnia, dementia, mixed anxiety disorders, asthma, overactive bladder, and other disorders of the brain.

R1's MDS (Minimum Data Set) dated February 8, 2024 shows R1 was rarely/never understood and had moderate cognitive impairment for daily decision making. R1 required supervision with eating and locomotion of 50 feet with a manual wheelchair. R1 required partial/moderate assistance with oral hygiene and locomotion of 150 feet with a manual wheelchair. R1 was dependent on facility staff for toilet and personal hygiene, bathing, bed mobility, dressing, and transfers between surfaces. R1 was frequently incontinent of bowel and bladder.

On March 8, 2024 at 1:00 PM, V4 (LPN-Licensed Practical Nurse) documented R1 had an unwitnessed fall on March 6, 2024 at 00:00 (12:00 AM).

The facility's initial report to IDPH (Illinois Department of Public Health) dated March 12, 2024 shows R1 sustained a fall on "approximately March 6, 2024" at "approximately 12:00 AM." The initial report continues to show: "Facility was notified that [R1] was admitted for abdominal distension and acute cystitis. The hospital notified the facility days later that test results showed [R1] had a subdural hematoma. Investigation initiated, final report to follow in five

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days."

On March 6, 2024 at 7:37 AM, V10 (Hospital Physician) documented: "[R1] is cooperative, she has bruising to her right eye, bruising to her face, bruising to the anterior chest ..."

On March 6, 2024 at 3:10 PM, V9 (Hospital Physician) documented: "[R1] has unintelligible speech. Was noted to have multiple bruises on the right side of her body which includes forehead, eyes, shoulder, forearm, axillary region ..."

R1's CT scan of the head, performed on March 7, 2024 at 10:55 AM shows: "Findings indicating holohemispheric acute subdural hematoma formation along the right cerebral hemisphere measuring up to 10 mm (millimeters) in diameter. There is localized mass effect with 3 mm of leftward midline shift. There are also subdural blood products layering along the right temporalis as well as with the right parafalcine regions posteriorly.."

On March 12, 2024 at 11:56 AM, V2 (DON-Director of Nursing) said, R1 had a caregiver/sitter in her room from 11:00 AM to 7:00 PM. "She was constantly trying to get up and was not able to walk. Her lower extremities were weak, and she still believed that she could walk. She tried to get up multiple times from the bed and the chair. She needs someone with her one on one. She needs someone with her most of the time. If she is sleeping, she is fine. We got word from the hospital that [R1] had a subdural hematoma. I set up the investigation right away. My conclusion was that she had an unwitnessed fall here that resulted in a subdural hematoma."

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On March 13, 2024 at 11:16 AM, V8 (NP-Nurse Practitioner) said, "[R1] had two falls in February. She has fallen in the past and has had multiple falls and has been sent to the emergency room for falling. She is very impulsive. She has no safety awareness. I was told she had bruising on her eye, and I ordered an X-ray and neuro checks around the clock. They never told me she had a fall. She is always found on the floor crawling. [V2] (DON) did notify me that [R1] had a subdural hematoma after she got to the hospital. A subdural hematoma is caused by hitting your head. Obviously this was something unwitnessed. She just came to us from a skilled nursing facility and already had two falls."

R1's fall care plan initiated on February 3, 2024 shows R1 had an actual fall related to medication side effects, weakness, debility, poor safety awareness and impulsivity. Interventions dated February 3, 2024 include, "CNA to provide frequent rounding (checks) on resident throughout the AM, PM, and night shift for safety." An intervention initiated February 13, 2024 shows: "Resident receives oral anticoagulant or NSAID (Non-Steroidal Anti-Inflammatory Drug), evaluate for bleeding/bruising post-fall."

The facility does not have documentation to show frequent rounding or checks were being done for R1.

The EMR shows the following physician order for R1 dated February 2, 2024 and discontinued on March 7, 2024 due to R1's hospitalization: "Start date: 2/2/2024 0400 (4:00 AM) Resident on frequent rounding. Every hour for safety precaution r/l (related) to fall risk. Frequency: Every hour. Schedule type: Every day."

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The facility does not have documentation to show hourly rounding was being done as ordered by the physician.

On March 13, 2024 at 2:55 AM, the EMR was reviewed with V3 (ADON-Assistant Director of Nursing). V3 acknowledged there is an order in R1's medical record to do hourly rounding due to frequent falls that was initiated on February 2, 2024. V3 (ADON) said, the order was entered incorrectly and was not visible to the nursing staff. "The nurse who received the order entered it incorrectly. Because of the way she entered the order, the nursing staff would not have been able to see the order and were not aware they should have been rounding on [R1] and documenting they did so."

2. The EMR shows R2 was admitted to the facility on August 3, 2023 with multiple diagnoses including pressure ulcer of the left heel, Wernicke's encephalopathy, seizures, weakness, psychotic disorder, other disorders of the brain, alcohol dependence with alcohol-induced anxiety, muscle weakness, and nicotine dependence.

R2's MDS dated February 6, 2024 shows R2 has significant cognitive impairment, uses a wheelchair for locomotion, is able to eat with setup help, requires substantial/maximal assistance with oral hygiene, bed mobility, and transfers between surfaces, and is dependent on facility staff for toilet hygiene, showering/bathing, dressing, and personal hygiene. R2 is frequently incontinent of urine, and occasionally incontinent of stool.

On March 13, 2024 at 10:44 AM, R2 was sitting up in his wheelchair in the hallway of the facility. R2 was wearing shoes on both feet that were

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untied and loose on his feet, with his heels out of both shoes and resting on the top of the back of his shoes. R2 had a visible scar on the right side of this upper forehead. R2 touched the scar when asked about it and said he fell and hit his head.

The facility's initial report to IDPH dated March 4, 2024 shows R2 was observed on the floor in his room, lying on his right side. Licensed nurse assessed for injuries and a laceration was noted to the head. R2 was sent to the hospital for evaluation and treatment.

Hospital records dated March 4, 2024 at 4:04 PM show R2 was seen in the emergency room of the local hospital for a laceration to the forehead. R2 received sutures and hospital discharge instructions show the sutures were to be removed after seven days.

On March 13, 2024 at 11:16 AM, V8 (NP) said R2 received sutures on his forehead after he fell at the facility. "[R2] is impulsive and has to be redirected due to his behavior and for poor safety awareness. The fall caused the laceration, and he needed stitches."

Facility documentation also shows R2 sustained a fall on February 13, 2024 at 7:20 PM after R2 was found on the floor next to his bed, and on March 4, 2024 at 12:20 PM when R2 had an unwitnessed fall and was found next to his bed.

R2's care plans show a fall care plan initiated August 9, 2023. No new fall interventions have been added to R2's care plan since December 26, 2023.

On March 13, 2024 at 1:17 PM, V2 (DON)

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acknowledged R2's care plan does not show any new interventions to prevent falls and said, "Our interventions include sending out a package for skilled nursing facility placement and requesting he be put on hospice, but his brother is not ready for that." V2 was unable to answer how those interventions would protect R2 from falling or sustaining injury related to falling if R2's family was unwilling to place him on hospice or if skilled nursing facility placement was not imminent.

3. The EMR shows R3 was admitted to the facility on December 30, 2014. R3 has multiple diagnoses including Huntington's disease, difficulty walking, weakness, mild cognitive impairment, dementia, and bipolar disorder with psychotic features.

R3's MDS dated January 8, 2024 shows R3 has severe cognitive impairment, is able to eat independently, is able to roll left to right in bed independently but is dependent on facility staff for all other bed mobility and toilet hygiene, showering/bathing, dressing, personal hygiene, and transfers between surfaces. R3 is always incontinent of bowel and bladder.

On March 13, 2024 at 10:46 AM, R3 was sitting in a wheelchair in a TV room outside of V2's (DON) and V3's (ADON) office. V2 and V3 were not present in their office. Seven other residents were present in the TV room with R3. No facility staff were present. R3's locked wheelchair was pushed up against a table. The table was pushed up against a wall. R3 had continuous jerky, involuntary movements. R3 was continuously observed fidgeting in her wheelchair. No facility staff came to the room to observe R3. At 11:04 AM, R3 was forcefully pushing her locked wheelchair away from the table with her hands.

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R3 was placing her feet on the floor and attempting to stand using her hands and arms and the support of the wheelchair to stand. R3 used a motion of throwing her body weight backwards into her wheelchair. The action of doing this made it possible for R3 to move her wheelchair approximately four feet away from the table. R3 was able to lean forward without any staff present and without staff intervention. R4 was sitting in the same room as R3. R4 started yelling at R3 to "sit down!" No staff were present to discourage R3's behavior of attempting to stand and pushing her wheelchair away from the table.

On February 17, 2024 at 6:40 PM, V12 (RN) documented a fall incident for R3: "Just prior to/at the time of the event [R3] appears to have been up on her wheelchair, watching TV in the TV room. Witness to the event includes: another resident. [R3] was trying to pick her shoes on the floor when resident suddenly slid out of the wheelchair." R3 did not sustain an injury.

On January 20, 2024 at 8:25 AM, V12 (RN) documented a fall incident for R3: "Just prior to/at the time of the event, [R3] appears to have just finished eating her breakfast. Witness to the event includes CNAs. At around 8:25 AM [R3] stood up and tripped over the footrest."

The EMR does not show R3 has a care plan specific to falls. R3's care plan entitled "Resident has risk factors that require monitoring and intervention to reduce potential for self-injury" was initiated on July 31, 2023. As of March 12, 2024, R3's care plan interventions had not been updated following her two most recent falls with new interventions to prevent falls.

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S9999	Continued From page 9 The facility's policy entitled Fall Prevention, revised "11/10/18" shows: "Policy: To provide for resident safety and to minimize injuries related to falls; decreases falls and still honor each resident's wishes/desires for maximum independence and mobility. ...5. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. 6. The unit nurse will place documentation of the circumstances of a fall in the nurse's notes or on an AIM for Wellness form along with any new intervention deemed to be appropriate at the time. The unit nurse will also place any new intervention on the CNA assignment worksheet. 7. Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed in the morning Quality Assurance meeting and any new interventions will be written on the care plan." (A)	S9999		