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	IL6006332	A. BUILDING: _____ B. WING _____	C 05/23/2024

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PEARL OF HINSDALE, THE	600 WEST OGDEN AVENUE HINSDALE, IL 60521

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S 000	Initial Comments Complaint Investigation: 2473902/IL173311	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)4) 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 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	S9999		

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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. Restorative measures shall include, at a minimum, the following procedures:

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

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:

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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 provide two person assistance during incontinence care and failed to implement a post fall intervention. This failure applies to 1 of 3 residents (R1) reviewed for falls in the sample of 3. This failure resulted in the resident falling off the bed and sustaining a left femur and a right shoulder fracture.

The findings include:

R1's EMR (electronic medical records) showed that R1 was sent to the ER (emergency room) on May 9, 2024 post fall and readmitted to the facility on May 17, 2024 after hospital stay with diagnoses of unspecified fall, subsequent encounter, nondisplaced fracture of lateral condyle of right femur, subsequent encounter for closed fracture with routine healing, fracture of unspecified shoulder girdle, part unspecified, subsequent encounter for fracture with routine healing, unspecified injury of head, subsequent encounter. R1's diagnoses prior to discharge to the hospital included morbid (severe) obesity due to excess calories, other idiopathic peripheral autonomic neuropathy.

Initial Consultation at ED (Emergency Department) on May 9, 2024 included the following information:

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R1 is a 62 year old female presented to ED for further evaluation after mechanical fall out of bed at the nursing home. R1 is on Xarelto (blood thinner) and primarily complained of headache where she hit her head, right shoulder pain and left knee and hip pain. ED evaluation with X-ray to shoulder shows comminuted displaced right neck humeral fracture primarily involving the humeral neck which is displaced up to 1.7 cm (centimeters) and also involves the humeral head cortex and tuberosities, soft tissue edema present. CT (Computed Tomography) of left knee shows fracture of both medial and lateral distal femur essentially nondisplaced extending into the tibiofemoral articular surface as well as patellofemoral articular surface. Orthopedic surgery was consulted for further management.

R1's quarterly MDS (minimum data set) dated March 5, 2024 showed that R1 was moderately impaired in cognition. The same MDS showed that R1 was dependent on staff for toileting hygiene. The MDS assessment showed that the term "dependent" included that helper does ALL of the effort. Resident does none of the effort to complete the activity or, the assistance of 2 or more helpers is required for the resident to complete the activity.

R1's Fall Risk Assessment dated March 5, 2024 showed that R1 was at high risk for fall with a score of 16.

R1's EMR showed that R1 was 264.0 pounds on May 3, 2024.

Facility Final Report of R1's fall incident dated May 9, 2024 to IDPH (Illinois Department of Public Health), included that during ADL (activities of daily living) care, R1 was repositioned on her

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left side and slid off bed. R1 complained of pain to right arm. Medical Doctor notified and R1 sent to ER via 911 for evaluation. R1 sustained injuries of right humeral fracture and left humeral fracture. The same report included that according to CNA (Certified Nursing Assistant) interview, she was on R1's right side and she assisted R1 to the middle of the bed so that she could clean her and change her linen and was unable to prevent R1 slipping off the edge of the bed.

Nursing progress notes dated May 9, 2024 included that per investigation of above incident, there was only one person present during care.

R1's care plan initiated December 23, 2020 included that R1 has ADL self care deficit related to obesity, muscle weakness which may lead to physical limitations low activity tolerance related to diagnoses of degenerative disease to left knee, and back, carpal tunnel, peripheral autonomic neuropathy.
Intervention created and initiated on March 8, 2024 included for staff to provides extensive to total assist in bed mobility, transfer, toileting check and change.....

R1's care plan revised May 09, 2024 included that R1 had an actual fall related to poor balance. Interventions created and initiated on May 09, 2024 included to transfer to ER 911 for evaluation. Upon return bariatric bed will be provided and 2 staff will assist for ADLs.
Interventions created and initiated on May 17, 2024 included : Protection /Safety Hazards/Peril: Staff will assess its physical environment, device, equipment, including furniture, appliances, beds, wheelchairs, etc. to ensure that it don't pose as a safety risk or hazard.

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On May 20, 2024 at 9:38 AM, R1 was seen lying in a regular sized bed and appeared morbidly obese and occupied the entire width of the bed and mattress with no extra space on either side. When asked if the bed/mattress size were adequate size for her, R1 remarked "No, both are too small." R1 stated that she was in a similar sized bed when the fall incident occurred. Regarding the fall incident of May 9, 2024, R1 stated "I fell when she (CNA) was changing me (providing incontinence care). She turned me towards the door (left side) to the edge of the bed and before you know it, I was on the floor. She was the only person changing me then. Now there are two. Happened after 5 (5:00 AM) in the morning." R1 stated that there were no side rails for her to hold on to while she was turned. R1 stated that she broke her right shoulder and left leg during the fall. R1 stated that the bedside table was there towards the left side during the fall.

On May 20, 2024 at around 10:20 AM, facility was asked to provide measurements of R1's mattress and bed.

On May 20, 2024 at 12:17 PM, V1 (Administrator) stated that R1 was on a 42-inch bed during her fall incident and was placed in a 42-inch bed when she was readmitted over the weekend. V1 stated that a 48-inch bed is considered a 'bariatric' bed.

On May 20, 2024 at 12:39 PM, V5 (Assistant Director of Nursing) stated that she did the root cause risk analysis post R1's fall and had intervention in R1's care plan that she (R1) would have a bariatric bed on readmission from hospital. V5 stated that a bariatric bed is 6 inch wider than R1's previous bed.

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On May 20, 2024 at 1:04 PM, V6 (Maintenance Director) stated that around 10:30 AM that morning, he was told to change R1's both bed and mattress from a 42 inch to 48 inch bed and mattress. V6 stated, that the 42-inch bed is extendable to a 48-inch bed. V6 stated that he was not notified earlier to do the same.

On May 20, 2024 at 2:15 PM, V3 (CNA) stated that she works the night shift and has always assisted R1 with incontinence care by herself. V3 stated that on May 9, 2024 at around 6:00 AM, while providing incontinence care for R1, she was on the right ride of R1 and turned R1 on to her left side towards the middle of the bed. V3 stated that the sheet underneath R1 was wet so she proceeded to change the whole bed and pulled the sheet from underneath R1. V3 stated that just as she turned to get the clean linen, R1 rolled off the bed on the left side towards the bedside table. V3 stated that she was unable to prevent R1 from sliding off the bed.

On May 20, 2024 at 10:28 AM, V4 (CNA) stated that she usually works the day shift and has taken care of R1 prior to her fall incident. V4 stated "I used to do her incontinence care by myself. I always pull her towards me and turn her so that she has more room."

On May 20, 2024 at 2:55 PM, V8 (MDS Coordinator) stated that toileting hygiene includes wiping the resident during incontinence care. V8 stated that R1 is not able to wipe herself. V8 stated that the term 'dependent' usually involves two or more staff.

On May 20, 2024 at 3:11 PM, V9 (R1's Physician) stated that the facility should follow their protocol

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S9999	Continued From page 7 regarding assistance or provide bariatric bed depending on whatever difficulty the patient has in bed. Facility Policy titled "Fall Prevention and Management" (last revised April 8, 2024) included as follows: Policy Statement: The facility is committed to its duty of care to residents and patients in reducing risk, the number and consequences of falls including those resulting in harm and ensuring that a safe patient environment is maintained. Procedures: 2. Fall interventions: b) High Risk Precautions will be implemented to residents and patients whose scores on Resident Family/Notification screen shows high risk will be considered on this precaution. 4. Fall Response: Investigate fall circumstances. Initiate Risk Management/Fall Event. 2.m. Safety hazards 5. Implement immediate intervention post fall at least within same shift. (A)	S9999		