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	IL6007322	A. BUILDING: _____ B. WING _____	05/17/2024

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S 000	Initial Comments Annual Health Survey Complaint Investigation: 2493101/IL172139	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 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 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	S9999		

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S9999	Continued From page 1 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. 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 observation, interview, and record review the facility failed to implement fall	S9999		

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prevention intervention to R53 who has history of fall. The facility also failed to ensure individualized fall prevention care plan interventions are in place upon admission for a resident who has history fall and fracture of left femur. This deficiency affects two (R53 and R229) of three residents in the sample of 32 reviewed for Fall Prevention Management.

This failure resulted in R229 having an unwitnessed fall and sustained acute comminuted left ischial pubic and tuberosity fractures that required hospitalization.

Findings include:

1. On 5/14/24 at 11:28AM, V6 Restorative nurse stated R229 admitted on 1/9/24 with history of falls from home and fracture of left femur. R229 was admitted to the facility for rehabilitation. R229 is non ambulatory and dependent with activities of daily living. She is alert but confused with poor safety awareness. V6 said that on 1/13/24, R229 attempted to get out from bed to go to the bathroom without assistance. She has unwitnessed fall and was sent out to the hospital for evaluation. V6 said that it is was protocol of the facility that resident with unwitnessed fall and currently on anticoagulant was sent to the hospital for evaluation. V6 said she does not know what happened with R229 after. V6 denied V22 Family member presented concern regarding R229 fall incident.

On 5/15/24 at 10:47AM, Review R229's medical records with V6 Restorative Nurse. R229 admitted on 1/9/24 with diagnosis listed in part but not limited to Repeated falls, Alzheimer's disease, Displaced fracture of greater trochanter of right femur, Fracture of left pubis, Displaced

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transverse fracture of shaft of left femur, History of falling, Muscle wasting and atrophy, Poly arthritis. Admission fall assessment done on 1/9/24 indicated R229 is at high risk for fall. R229 has history of falls with injury. Interim care plan dated 1/9/24 indicated that R229 is at risk for falls related to current medication use, poor safety awareness, unsteady gait, and disease process. Interventions: Restorative program to prevent further falls. Skilled rehabilitation therapy evaluation. Informed V6 that R229 did not formulate individualized care plan based on admission fall assessment done on 1/9/24 indicating that she is at high risk for falls due to history of falls with injury. Fall care plan was not updated until 1/15/24 after R229 had unwitnessed fall with injury dated 1/13/24.

R229's hospital record dated 1/13/24 indicated a 79-year-old female with past medical history of Hyperlipidemia, Hypertension, Gastro Esophageal Reflex Disease, Depression, Anxiety, Thyroid, Coronary Artery Disease, Dementia presenting with chief complaint of fall from nursing home on left side present with pelvic pain found to have pelvic fracture. She had right femur intermedullary nail fixation right femur in Dec 2023. She complaint of pain 10/10. Ortho consult. Diagnosis: Acute traumatic left pelvic fracture. Imaging: Acute left ischial pubic ramus and tuberosity fractures, minimally displaced.

Review Post fall investigation completed by V6 Restorative Nurse dated 1/15/24 indicated: Unwitnessed fall with injury: fracture of left pubis. 1/13/24 at 15:10. Resident's room. Attempting to stand or transfer. Awake, confused, poor safety awareness. At risk for fall. History of falls 12/21/23 from home. Root cause analysis: She was last noted sitting on the bed. R229 attempted

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to ambulate to the bathroom without assistance or using the call light. Interventions to address incident: The resident was sent to the hospital for evaluation. Upon return her room was moved closer to nursing station, she was given ultra-low bed.

On 5/15/24 at 2:10PM, V9 Fall Coordinator said that interim care plan intervention is formulated within 24 hours after resident admission. Resident who is at risk for fall should have fall preventions interventions in placed based on fall assessment and resident needs upon admission.

On 5/15/24 at 2:48PM, Informed V1 Administrator and V2 Director of Nursing (DON) of above concerns.

On 5/15/24 at 5:58PM, V27 Registered Nurse (RN) said that she completed the unwitnessed fall incident report of R229, but she did not observe R229 on the floor. The agency nurse who worked on 7a-3p shift 1/13/24 was the one who observed R229 on the floor after she fell and assessed her. V27 said that the incident was endorsed to her, and she sent R229 to the hospital for evaluation.

On 5/16/24 at 10:12AM, Surveyor requested V2 DON for the nurse and CNA who worked with R229 to be interviewed.

On 5/17/24 at 10:45AM, V38 Agency Nurse said that she worked with R229 the day she (R229) fell on 7a-3p shift. V38 said that R229 fell during shift change. V38 said that R229 is high risk for fall. V39 said R229 had unwitnessed fall in her room. She was found sitting on the floor next to her bed, R229 said that she wanted to go to the bathroom. R229 was assisted with 2 persons assist using mechanical lift back to bed. R229 denied any

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S9999	Continued From page 5 pain. R229 was sent to the hospital for evaluation. V39 Agency CNA who worked with R229 on the day of the fall was not available for interview. 2. On 5/14/24 at 10:48AM, Observed R53 lying in bed on slanting position (R53's head was on the left side of the bed with her forehead touching the side rail and her feet are on the right side of the foot part of the bed). The bed is on high position (approximately 30 inches from the floor) with bilateral floor mats on the side of bed. Called V17 CNA (Certified Nurse Assistant) and V18 Agency RN (Registered Nurse) who are assigned to R53 and showed observation made. Both said that R53's bed should be on the lowest position. V18 took the bed control on the right side of the bed, away and out of reach from R53. V18 adjusted the bed to the lowest position. V18 said that R53 had breakfast in bed and probably who ever pick up her breakfast tray forgot to put her bed in the lowest position after eating. V17 CNA denied that she picks up R53's breakfast tray after she ate. On 5/14/24 at 12:12PM, V9 Fall Coordinator said that she is responsible for ensuring implementation of fall prevention policy. V9 said that one of their fall prevention interventions is providing low bed. Resident on low bed should be always on the lowest position when in bed. V9 said that R53 is at high risk for fall, had history of falls and on fall prevention monitoring risk. Informed V9 of above observation made with R53. V9 said that R53 is on low bed and should be in the lowest position when in bed. On 5/15/24 at 10:12AM, V2 DON said that they are expected to implement fall care plan interventions to prevent falls.	S9999		

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S9999	Continued From page 6 On 5/15/24 at 2:48PM, Informed V1 Administrator of above concerns. R53 is admitted on 6/9/23 with diagnosis listed in part but not limited to Metabolic encephalopathy, Pain in left knee, Dementia. Admission fall assessment dated 6/9/23 indicated that R53 is at high risk for fall due to history of falls. Care plan indicates that R53 is at risk for falls related to current medication use, poor safety awareness, unsteady gait, and disease process. Intervention: Bed should be in a lowest possible position. R53's most recent fall incident dated 9/11/23 indicated unwitnessed fall without injury from bed in her room. Facility's policy on Fall occurrence revised 7/17/23 indicates: Policy statement: to ensure that residents are assessed for risk for falls, that interventions are put in place and interventions are re-evaluated and revised as necessary. Procedures: 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. 3. If resident has fallen, the resident is automatically considered as high risk for falls. Facility's policy on Care Plan Revised 7/27/23 indicates: Policy statement: to ensure all care plans including base line care plans are in conjunction with the federal regulations. Procedures: 1. During admission, the facility may put in place	S9999		

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S9999	Continued From page 7 baseline care plans within 48 hours to address resident's care. 2. The baseline care plan at minimum should include initial goals based on admission orders, physician orders, dietary orders, therapy services, social services and PASARR recommendations if applicable. (A)	S9999		