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| S 000 | Initial Comments<br><br>Facility Reported Incident of February 27, 2024<br>IL171694 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610 a)<br>300.1210 b)<br>300.1210 c)<br>300.1210 d)6)<br>300.1220 b)3)<br><br>Section 300.610 Resident Care Policies<br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>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 | S9999 | | |

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

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These requirements are not as evidenced by:

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| S9999 | Continued From page 2<br><br>Based on observation, interview, and record review, the facility failed to monitor a high fall risk resident (R2) while in bed, failed to put in additional interventions to address R2's behavior of moving/wiggling around the bed, and failed to keep the call light within reach. This affected one of three residents (R2) reviewed for fall prevetion interventions. This failure resulted in R2 suffering a brain bleed in two areas of the brain after the fall.<br><br>Findings Include:<br><br>R2 is a 56 year old with the following diagnoses: chronic obstructive pulmonary disease, and nontraumatic intracranial hemorrhage.<br><br>The Admission Hospital Records, dated 2/17/24, documents R2 was sent to the hospital for altered mental status. R2 was noted with elevated blood pressure, has poor attention, span, and has severe encephalopathy. A CT (Computed Tomography) scan of the brain was completed on 2/13/24 and no brain bleeds are documented on this scan.<br><br>A Nursing note, dated 2/23/24, documents R2 is a new admission. R2 often yells out but when staff approaches, R2 is not able to verbalize what R2 needs. R2 educated on the use of the call light but continues to yell out.<br><br>The Fall Risk Observation, dated 2/23/24, documents a score of 17, indicating R2 is a high fall risk. R2 is a high fall risk due to having intermittent confusion, being confined to a chair, needing assistance with elimination, being newly admitted to the facility, and has had a recent decline and functional status. | S9999 | | |

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| S9999 | Continued From page 3<br><br>The Full Clinical/Body Observation, dated 2/23/24, indicates R2 was admitted on this day from the hospital and is easily distractible, has impaired memory, and disorganized thinking.<br><br>A Nursing note, dated 2/24/24, documents R2 is alert to self only. R2's behavior remains anxious at intervals. R2 is not able to make needs known and is dependent and all areas of ADL care.<br><br>A Nursing note, dated 2/25/24, documents R2 is not ambulatory. R2's behavior of yelling out and asking for help from staff, but when staff responds, R2 cannot say what is needed. R2's behavior remains anxious at intervals. R2 is not able to make needs known clearly. R2 is dependent in all areas of ADLs.<br><br>A Nursing note, dated 2/27/24, documents R2 is noted on the left side of the bed lying on the floor by the wall. The bed was in the lowest position and the call was attached to the bed, which R2 did not pull for assistance. A small amount of blood was noted from the left forehead. The physician ordered to send R2 to the hospital for a medical evaluation. R2 was placed in a wheelchair to the nurse's station for observation.<br><br>The Fall Event, dated 2/27/24, documents the form was not completed post fall and to see progress note for fall information.<br><br>The Fall Risk Observation, dated 2/27/24, documents a score of 15 indicating R2 is still a high fall risk.<br><br>The Care Plan, dated 2/27/24, documents R2 has a history of falls due to altered mental status and lower extremity weakness. Documented interventions on this day include observe R2 | S9999 | | |

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frequently and place in supervised areas when out of bed, keep call light within reach at all times, and place R2 in a fall prevention program. The intervention for fall mats was not placed until 3/5/24.

The Minimum Data Set, dated 2/27/24, documents Section GG, R2 is a substantial/maximal assist for rolling in the bed, dependent for all transfers, and cannot ambulate.

The Hospital Records, dated 2/28/24, documents R2 presented to the emergency department status post fall. The nursing home reported R2 fell and hit R2's head. R2's baseline is alert and oriented times one and is currently acting normal. Upon assessment, a 2 cm superficial, lateral abrasion was noted to the left lateral brow. No exposed subcutaneous tissue was noted. The CT of the head documents there is a combination of a subdural and intraparenchymal hemorrhage in the bilateral, parasagittal parieto - occipital lobes with adjacent edema. Neurosurgery was consulted and R2 was admitted to the intensive care unit for observation.

The Facility Reported Incident, dated 2/28/24, documents R2 admitted to the facility on 2/23/24 after a recent hospitalization. At the hospital, R2 was treated for altered mental state and hypertensive encephalopathy. R2 was also diagnosed with polysubstance abuse, drug induced seizures, and generalized weakness. On 2/27/24, R2 had an unwitnessed fall in R2's room. Upon entering the room, R2 was noted lying on the left side of the bed. The nurse performed to a head to toe assessment and noted a laceration above the left eyebrow with minimal bleeding. R2 was asked what happened and how did R2 fall, R2 responded, "I don't know." The nurse received

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orders to send R2 the hospital for medical evaluation. The facility was notified R2 was being admitted with a diagnosis of brain bleed. The IDT (Interdisciplinary Team) met and believed the fall may be related to acute medical change. R2 returned to the facility on 3/3/24 with a diagnosis of UTI (urinary tract infection), sepsis, and bilateral intracranial bleeds.

A Nursing note, dated 2/28/24, documents the hospital called the facility to notify R2 had brain bleed and is being transferred to the intensive care unit.

A Nursing note, dated 2/28/24, documents the IDT (Interdisciplinary Team) met to discuss the fall that was not witnessed and occurred yesterday. R2 was found in R2's room lying on the floor on the left side of the bed. When asked why did R2 fall, R2 was not aware. A laceration was noted to the left eyebrow. The physician ordered to send R2 to the hospital for acute medical evaluation.

A Nursing note, dated 3/4/24, documents the IDT met today after R2 returned from the hospital. R2 had a room closer to the nurse's station, frequent monitoring, bed in the lowest position in mats placed on both sides of the bed for interventions related to the root cause of the previous fall.

The Minimum Data Set, date 3/5/24, documents a Brief Interview for Mental Status score as 12 (moderate cognitive impairment).

On 5/2/24 at 12:55PM, R2 was lying in bed awake. R2's bed was low to the floor and had one side of the bed pushed against the wall completely, so R2 is only able to exit the bed from one side. There is one fall mat in place that is the

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length of the bed. The call light was clipped to the comforter of the bed that was at R2 ' s feet. When asked to sit up and reach the call light to see if R2 was able to reach, R2 only stared at the surveyor and did not move. R2 is alert and oriented times one at the time of this interview. R2 was only able to state R2's full name. R2 was not able to state date, R2's birthdate, where R2 was, or who the president is. R2 did not remember any having any falls or being injured in any falls. At 1:04PM, V6 (Assistant Director of Nursing/ADON) was called into the room and showed the position of the call light. V6 stated the call lights are normally clipped up on residents' pillows but R2 had the call light placed by R2 ' s feet because the position of the bed needed to be up against the wall for R2's safety. V6 reported R2 needed to be facing the doorway so staff could check on R2 as they passed R2 ' s room.

On 5/2/24 at 1:30PM, V4 (Restorative Nurse) stated interventions are put into place based on resident behaviors. V4 reported R2 is part of the fall program in the facility due to having recent falls and being a high fall risk. V4 stated all the interventions that are in place should be charted in the care plan the day they were initiated. V4 reported R2 can move a little bit in bed but cannot ambulate. V4 reported the call light should be clipped where R2 can reach it and not the the feet.

On 5/2/24 at 2:05PM, V6 stated when R2 was interviewed about the fall, R2 did not remember falling and was not able to verbalize what R2 was doing to cause the fall. V6 reported R2 was agitated and moving a lot when R2 first arrived to the facility. V6 stated restorative will do an assessment and put in interventions for a resident based on the assessment. V6 reported

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all interventions are documented in the care plan. V6 stated, "It would have made sense to put the bed low and falls mats in place," due R2 moving around a lot. V6 reported R2 is alert and oriented times one.

On 5/3/24 at 8:07AM, V9 (CNA) stated when R2 first arrived to the facility, R2 had a behavior of yelling out and wiggling around the bed or wheelchair. V9 reported R2 was "always trying to get out of bed." V9 stated R2 was not able to move around in bed a lot, but the moving R2 was able to do would change R2's position in bed. V9 was not able to remember if the fall mat was put in place before or after the fall. V9 reported R2 is now safe because R2 has R2's bed placed against the wall.

On 5/3/24 at 8:18AM, V10 (Nurse) stated R2 was admitted back from the hospital after a fall and R2 had a brain bleed. V10 described R2 as a restless person in bed but was never able to ambulate. V10 reported R2 did a lot of crying and yelling out and could not keep still. V10 stated R2's bed was low and a mat was in front of the bed when R2 returned from the hospital, but V10 was not able to remember what interventions were in place at the time of the fall. V10 reported R2 was a high fall risk before and after the fall. V10 stated R2 is alert and oriented times one. V10 reported intervention should be in place when it is noticed a resident is having a behavior to try and stop the fall. V10 reported the call light should always be within reach of a resident even if they cannot use it to help to keep the resident safe.

On 5/3/24 at 12:19PM, V12 (Nurse) stated when R2 was first admitted, R2 was not very active, but became more active on the next day and yelled

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more. V12 reported R2 was moving around more in the bed. V12 stated the fall happened in the evening and V13 (CNA) told V12 about the fall. V12 was not able to remember time frames but stated the last time R2 was checked R2 was awake but not moving around. V12 reported R2 fell off the side of the bed and was between the bed and the air conditioning unit. V12 stated R2 had a small laceration and was sent to the hospital for an evaluation because R2 hit R2's head. V12 was unaware of why R2 is a high fall risk. V12 stated a resident is a high fall risk if they have previous falls, and unsteady gait, or keep trying to get up on their own. V12 reported R2's room at the time of the fall was in the middle of the hallway and staff tried to check on R2 as they walked on the hall. V12 denied being aware of any increased monitoring on R2 on the day of the fall. V12 stated a fall mat was down in front of the bed at the time of the fall, but was not on the other side of the bed where R2 fell. V12 reported fall mats were placed on both sides of the bed when our to return from the hospital. V12 denied being aware of why fall mats were not on both sides of the bed.

On 5/3/24 at 1:23PM, V13 (Certified Nursing Assistant/CNA) stated R2 was fed around 5:30 PM and was taken back to bed on the day of the fall. V13 reported R2 was found around 6-7 PM. V13 stated R2 was acting like normal and was "all over the place." V13 reported R2 is able to roll all around the bed. V13 stated R2 was found in between the bed and the radiator on the floor after yelling out for help. V13 reported a fall mat was down on the opposite side of the bed from where R2 fell. V13 stated R2 is a smaller, thinner person and can fit into small places, like the space between the bed and the radiator. V13 reported R2 was a high fall risk and staff just kept

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checking on R2 when they walked on the hall. V13 was not aware why the fall mats were on both sides of the bed at the time of the fall.

On 5/6/24 at 2:40PM, V14 (Primary Physician) stated a brain bleed can occur from a lot of things, especially if someone is on blood thinners. V14 reported a brain bleed can happen spontaneously, with a slight bump to the head, or something more severe. V14 stated interventions are put in place based off the residents risk of fall. V14 reported if all the proper interventions were place then this incident could not have been prevented. V14 stated if interventions are needed, they should be put in place for the safety needs of the resident. V14 reported R2 had a behavior of getting on a bed and yelling.

The policy titled, "Falls - Clinical Protocol," dated 08/2008 documents, " ... Treatment/Management: 1. Based on the proceeding assessment, the staff and physician will identify permanent interventions to try to prevent subsequent falls into address risks of serious consequences of falling ... 2. If underline causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature of category of falling, until falling, reduces or stops, or until the reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance)."

(A)