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S 000	Initial Comments Facility Reported Incident of 6/6/24/IL174523	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 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 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.	S9999		

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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 are not met as evidenced by:

Based on interview and record review the facility failed to ensure safe positioning in a wheelchair was provided during care of a resident. This failure resulted in R1 sliding out of her wheelchair, being lowered to the floor, and sustaining a fracture of her left leg on 6/6/24.

The findings include:

The MDS (Minimum Data Set) dated 6/4/24 for R1 showed severe cognitive impairment, dependent on staff for oral hygiene, toileting, bathing, upper body dressing, lower body dressing, and personal hygiene. The MDS showed diagnoses including hypertension, gastroesophageal reflux disease, thyroid disorder, dementia, anxiety disorder, depression, psychotic disorder, senile degeneration of the brain, idiopathic neuropathy, history of falling, mild cognitive impairment, difficulty walking, and sleep disorder. Osteoporosis was not marked as a diagnosis.

The Nurse's Note dated 6/6/24 at 7:34 PM showed, CNA (Certified Nursing Assistant) on

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duty reported having to lower the resident to the floor due to starting to slide out of wheelchair. CNA states, "She was sliding out and I was unable to get her back in wheelchair, so I lowered the resident to the floor." Upon entering the resident's room this nurse observed the resident on the floor by the side of the bed. Resident noted to be alert with confusion which is the norm for the resident. No rotation or deformities noted during this time. No range of motion was documented as being performed as part of the nurse's assessment.

The Administration Note for R1 dated 6/7/24 at 4:29 AM showed, R1 was given 10 mg of Morphine by mouth due to "crying out saying she hurts."

The Nurse's Note for R1 dated 6/7/24 at 10:55 AM showed, Guest up per usual, did complain of left knee pain, no injury noted on assessment. No swelling or redness, Guest given hydrocodone 5/325 mg as scheduled.

The Administration Note for R1 dated 6/8/24 at 8:56 AM showed R1 was given 10 mg of Morphine for complaints of continuous left leg pain.

The Nurse's Note for R1 dated 6/8/24 at 11:04 AM showed, Resident complaining of left leg pain frequently this shift, crying often in pain.

The Administration Note for R1 dated 6/8/24 at 11:05 AM showed R1 was given 10 mg of Morphine for left leg pain.

The Administration Note for R1 dated 6/8/24 at 6:34 PM showed R1 was given 10 mg of Morphine but does not state where R1's pain was

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located.

The Nurse's Notes dated 6/9/24 for R1 showed, at 8:20 AM R1 was complaining of extreme leg pain this morning, staying in bed because of pain with movement. R1 was comfortable when not moving. The nurse positioned R1's left leg on pillow and had her right foot in an offloading boot. The nurse was using hot packs for R1's pain. At 9:23 AM, the note showed a portable x-ray was ordered for R1's femur and knee due to a fall with increased pain and decreased mobility. At 1:25 PM, V11 (R1's daughter) was contacted and a message was left. V12 (R1's son) was called, and he stated to not do the x-ray because it causes R1 extreme stress especially with her dementia, and she gets physical. V12 wanted R1 to be kept comfortable at the facility. At 1:55 PM V11 called back, the nurse updated her on everything, and she agreed with V12 to keep R1 comfortable at the facility.

The Administration Note for R1 dated 6/9/24 at 11:15 PM showed R1 was given 10 mg of Morphine for complaints of left leg pain with movement.

The NP (Nurse Practitioner) Note for R1 dated 6/10/24 showed, R1 was seen for chronic disease management, medication review, follow up status/post fall and left leg pain. R1 transfers via full mechanical lift. Today, R1 is having difficulty moving her left lower extremity at the knee. When the knee is attempted to be flexed, she will yell out that she is having pain. She is noted to have a bruise just below her left knee and her left knee is swollen and painful to touch. On 6/7/2024, staff reported that R1 was lowered to the floor, no injuries were noted. She was up per her usual and did have some complaints of left knee pain

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as the day went on. On 6/8/2024, during the night, she denied having any pain however, during the day she complained of left leg pain. She continued having left leg pain with decreased mobility in her left knee and on 6/9/2024, orders were written for a left femur x-ray however, when family was contacted about obtaining the x-ray, family did not want the x-ray obtained. Family did not want the x-ray completed as R1 does not tolerate imaging well and reported that x-rays caused her increased stress as she has dementia. X-rays were not obtained, and conservative treatment was requested and to keep resident comfortable.

The Administration Note for R1 dated 6/10/24 at 3:30 AM showed R1 was given 10 mg of Morphine due to cares were going to be done so the medication was given ahead of time to prevent severe pain.

The Nurse's Note dated 6/10/24 at 3:43 AM showed, Resident has a deformity to the left mid-thigh area and when asked where she hurts at, she pointed to that spot. She cries out in pain with any movement of that leg with and without as needed Morphine sulfate. Note left for NP to assess. At 3:40 PM showed, spoke with daughter "V11" who didn't realize that the order for X-ray was for portable. So that X-ray could come to guest room. She wants the X-ray done; she just didn't want her mother to have to transfer to hospital. At 3:49 PM, Radiology here to do x-ray, V10 gave verbal orders for mobile x-ray to radiology.

The X-Ray results dated 6/10/24 for R1 showed, Findings: Buckling of the anterior/medial cortex of the proximal tibia. Associated lipohemarthrosis of the knee. Intact internal fixation hardware.

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Impression: Medial tibial plateau fracture. No osteoporosis was documented on the x-ray.

The NP Note dated 6/11/24 for R1 showed, Follow-up x-ray on left lower leg, left lower leg pain. R1 is having difficulty moving her left lower extremity at the knee. When the knee is attempted to be flexed, she will yell out that she is having pain. She is noted to have a bruise just below her left knee and her left knee is swollen and painful to touch. On 6/7/2024, staff reported that R1 was lowered to the floor, no injuries were noted. She was up per her usual and did have some complaints of left knee pain as the day went on. On 6/8/2024, during the night, she denied having any pain however, during the day she complained of left leg pain. She continued having left leg pain with decreased mobility in her left knee and on 6/9/2024, orders were written for a left femur x-ray however, when family was contacted about obtaining the x-ray, family did not want the x-ray obtained. Family did not want the x-ray completed as R1 does not tolerate imaging well and reported that x-rays caused her increased stress as she has dementia. X-rays were not obtained, and conservative treatment was requested and to keep resident comfortable initially however, on 6/10/2024 at approximately 3 PM, staff notified this writer and stated that family is agreeable to a portable x-ray. R1 continues to have difficulty moving her left lower extremity at the knee. Plan: Closed fracture of medial portion of left tibial plateau, initial encounter: Received final radiology report this morning and noted medial tibial plateau fracture on the left. Based on the location of her fracture, I would recommend orthopedics to evaluate. At approximately 7:55 AM, called and left message on machine for POA (power of attorney), V11. Did not receive a call back. Also contacted V12 (R1's son) and

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message was left on his machine. At approximately 8:45 AM, received a return call from V12. He was informed that the left lower leg does have a fracture noted and because of the potential risks associated with this type of fracture, an orthopedic evaluation is recommended. V12 stated that he does not want to treat aggressive and is not interested in an orthopedic evaluation and would prefer comfort care/conservative measures and hospice services to reevaluate. Non-weightbearing to left lower extremity. Elevate for comfort. Use ice or heat per patient's preference for discomfort. Continue acetaminophen, hydrocodone/APAP (acetaminophen), and morphine for comfort.

The Long-Term Care Facility & IID - Serious Injury Incident and Communicable Disease Report dated 6/11/24 for R1 showed she had a fall with physical harm. The CNA (Certified Nursing Assistant) was getting the resident ready for bed. The CNA was assisting the resident to remove her shirt and put a gown on. The resident started to slide out of her wheelchair. The CNA lowered the resident to the floor, so the resident was sitting on the floor with her legs out in front of her. The CNA states the resident's legs slid forward between her own legs.

The "Interviews" that were conducted by V2 DON (Director of Nursing) showed, on 6/10/24 V7 CNA (Certified Nursing Assistant) stated, "I was trying to get her (R1) ready for bed." V7 states she was taking her shirt off and R1 was sitting on the edge of the wheelchair and started sliding. V7 attempted to pull her hips back but couldn't and had to lower her to the floor. At that time, V7 was in front of the resident facing her. The resident's legs were tucked between her legs during the transfer. V7 does not recall if the wheelchair was

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locked or not or if the pedals were on or off but she does state that is her regular practice. V7 then states she put a gown on her for dignity and left her to go get the agency nurse. She states the resident complained of right leg pain at the time of the incident. V7 states she was unable to find her hall partner, but she did find V8 CNA and V9 CNA who came to the room to assist. V7 reports that the resident's room was crowded so she left to answer call lights.

On 6/22/24 at 10:36 AM, R1 was laying on her right side in bed with V4 RN (Registered Nurse) at her bedside. R1 had a low bed to the floor. R1 was confused and when asked if she fell, she did not remember falling. R1 complained of pain below her left knee. V4 stated she was not at the facility the day R1 fell. V4 stated she was told a CNA was getting R1's gown on and R1 must have slid forward. R1 was helped to the floor. R1 was in a regular wheelchair at that time. R1 must have been too close to the edge (of wheelchair) and slumped in the chair to my understanding. R1 fell on a Thursday night, and I was here the Saturday and Sunday after the fall. On Saturday R1 had pain. R1 has pain medication. On Sunday her pain was bad; I got an x-ray order.

On 6/22/24 at 11:38 AM, V1 (Administrator) stated, R1 was lowered to the floor by a CNA. The CNA was taking R1's shirt off and R1 was in her wheelchair. R1 was sitting towards the end of the chair and slid out of the chair with her legs straight. The CNA could not remember if the footrests were on or not. The CNA got the nurse, and the nurse came down. They got R1 up from the floor using a mechanical lift and put her to bed. They didn't realize there was an injury at that time because R1 is always crying out in pain. They noticed bruising but not that day; it was a

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few days later. We offered to get an x-ray, but the family refused; R1 gets agitated with x-rays. I think they assumed we would take her to the hospital. Since we are connected to the hospital, we wheel residents over there. The second time an x-ray was brought up the family agreed to a portable x-ray. The portable x-ray showed a fracture. V2 DON (Director of Nursing), the NP and her family talked about a plan of care, and it is in her notes.

On 6/22/24 at 1:02 PM, V6 CNA stated, it is the safest to have a resident all the way back in their wheelchair with the resident sitting straight up and down. V6 stated residents should never sit at the edge of the chair because the resident could slide out and fall. It is not safe.

On 6/22/24 at 1:31 PM, V2 DON (Director of Nursing) stated, I interviewed V7 CNA. She was getting R1 ready for bed. R1 uses a mechanical lift for transfers. V7 was waiting for her teammate. V7 was taking R1's shirt off. R1 was at the edge of her seat. R1 slid forward and V7 grabbed R1's pants to try and pull R1 back. V7 couldn't so she lowered R1 down to the floor. R1 hollers and is a little combative. Staff are aware of her behaviors. They know how to handle R1's behaviors. V7 had taken R1's shirt off. V7 put R1's gown on when she was on the floor. I think she acted appropriately; there is nothing to be done differently. I interviewed the nurse on duty, V8 CNA, and V9 CNA and all of the statements were the same on how R1 looked. I did ask if anyone hit her leg on the mechanical lift and they said they didn't. I talked to V4 RN (Registered Nurse) the nurse on duty after the incident when R1 had increased pain. V4 talked to V11 (R1's daughter/POA) and V12 (R1's son) and they wanted the comfort approach for the resident. As

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soon as the family wanted an x-ray, we had a portable done here. V2 stated the CNAs have competency training. On May 1st (2024) they just had a safe patient handling training. Positioning in a wheelchair would be part of the safe patient handling program. V2 stated a resident sitting at the edge of the chair could contribute to a fall. A resident that is dependent with care would be more at risk of being pulled forward in their chair when taking her shirt off. V2 stated the CNAs are trained and would know this.

On 6/22/24 at 1:47 PM, V8 CNA stated, from what I know V7 CNA claims it was an accident. She was pulling R1's shirt off and R1 slipped to the floor. V8 stated her and V9 CNA got R1 up off the floor and V7 wasn't in the room. At the time R1 complained of left thigh pain. V8 stated depending on R1's mood it could take 1 or 2 people to get her undressed. R1 doesn't just slip out of a wheelchair. R1 was laying on the floor like she would if you were going to do a stand pivot transfer. R1's feet were in the direction of the head of the bed and her head was at the direction of the foot of the bed. R1 was on the left side of the bed, and you can't get a mechanical lift in that way so R1 would have been facing the door with her back to the bed. R1's butt and back is always at the back of her wheelchair. R1 has never slid out of her chair before. We don't position a resident at the edge of the chair, especially a resident that uses a mechanical lift. They would be at risk for falling out. The resident always has to be at the back of the chair. R1 used to be a stand pivot transfer but it was stopped because she wouldn't bend her knees and stand. R1 would keep her legs straight out. R1 had a bruise under her left knee a few days later. I saw the agency nurse do vitals, but I did not see her do an assessment. I told her R1 had

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pain and she should probably assess R1.

On 6/22/24 at 2:07 PM, V7 CNA stated, R1 was screaming when I got to her room. R1 was sitting close to the edge of her seat. I stood in front of her with her legs between mine. I took R1's shirt off, turned to get her gown, R1 started sliding, and I lowered her to the floor. I put her gown on her. I moved the wheelchair from behind her and went and got the nurse. I did not see any injuries on her. The nurse tried to ask where it hurt. The nurse wasn't moving R1's limbs to see if it caused more pain. R1 screamed whenever the nurse tried to touch her. The nurse did check R1; it was just not as thorough as I am used to seeing. I don't know if the nurse went back in there to check on her or not. V7 stated residents are to be positioned to the back of the wheelchair so they don't fall out, but she was getting R1 ready for bed and R1 was already at the edge of her chair.

On 6/22/24 at 2:26 PM, V3 LPN (Licensed Practical Nurse) stated, the girl came out of the room and said the resident was on the floor. The CNA said the resident was at the edge of her chair and she couldn't get her back in her chair, so she lowered the resident to the floor. The CNA was trying to take the resident's shirt off and put a nightgown on. I don't know how the resident got to the edge of the chair. R1 was moving around in her chair but was not sitting at the edge of her chair when she saw her before that. V3 stated R1 was on the floor in her room when she went into the room. V3 stated she did an assessment; she was feeling for breaks, pain, or injury. V3 stated she did range of motion. V3 denied that R1 had any complaints of pain. V3 stated she put an incident report in the doctor's box. The nurse that she was working with that day told her to do that. The nurse told her that she didn't have to contact

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anyone if there wasn't an injury.

On 6/22/24 at 2:47 PM, V10 NP (Nurse Practitioner) was called, and a message was left for her to return the call. A return call was not received prior to the end of the investigation.

On 6/22/24 at 2:52 PM, V11 (R1's daughter/POA) was called, and a message was left. A return call was not received prior to the end of the investigation.

On 6/22/24 at 3:01 PM, V1 (Administrator) stated, they presumed R1's fall caused R1's leg fracture. V1 stated there is nothing else that could have caused it. R1 did not have any other mechanism of injury that could have caused it. V1 stated she knows R1 was osteopenic but R1 wasn't standing and had it just break.

The facility's Safe Lifting Procedure policy (8/2022) showed, it is expected that the safe patient handling policy be followed at all times. The policy did not show proper body mechanics in a chair prior to transferring a resident.

The facility's Positioning the Resident policy (6/2024) did not show how a resident was to be safely positioned in a wheelchair.

On 6/22/24 the facility's Fall Policy was requested and not received.

(A)