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| S 000 | Initial Comments<br><br>Complaint Investigation: 2499065/IL180447 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violation:<br><br>300.610a)<br>300.1210a)<br><br>Section 300.610 Resident Care Policies<br><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><br>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 resident's comprehensive assessment, which | S9999 | | |

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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)

These regulations were not met as evidenced by:

Based on interview and record review, the facility failed to identify a resident (R1) as a high fall risk after new onset shuffling of gait and failed to put interventions on the care plan in regards to the shuffling. This affected one of three residents (R1) reviewed for fall prevention interventions. This failure resulted in R1 getting up unassisted and falling causing a laceration to the forehead that needed repair at the hospital with three to four stitches.

Findings include:

R1 is a 70 year old with the following diagnosis: dementia, schizophrenia, and epilepsy.

A Nursing note dated 8/16/24 at 6 AM documents the CNA reported to the nurse that R1 fell in R1's room. R1 stated that R1 lost R1's balance while trying to use the bathroom. R1 had a small laceration to the right forehead. The wound was cleaned and R1 was sent to the hospital via 911.

An Admission Summary note dated 8/16/24 documents R1 returned from the hospital with 3 to 4 stitches noted and facial bruising.

The Hospital After Visit Summary Record dated 8/16/24 documents R1 was seen in the

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emergency room for a fall from the bed and was diagnosed with a head injury. There was a cut on the forehead. R1 had stitches/tape to repair the laceration.

On 11/14/24 at 12:30PM, R1 was sitting in the dining room waiting for the lunch meal. R1 did remember falling but was unable to state the date. R1 was able to report the fall happened at night. R1 stated R1 fell while getting up from bed but was not able to remember why R1 was getting out of bed. R1 reported R1 did have an injury to the head that required stitches. There was a scar about one inch long above R1's right eye brow. R1 confirmed this was from the fall. R1 was not able to remember what happened after that fall except that R1 went to the hospital. R1 stated that R1 "walks fine" and denied needing any help. R1 reported R1 now uses a wheelchair to get around the facility. R1 then stood up and walked over to the wheelchair. R1 has a shuffled gait. R1's mental status was checked and R1 was alert and oriented times two. R1 stated that date and location correctly but was not able to name the current president.

On 11/14/24 at 1:15PM, V2 (Restorative Aide) stated R1 has been in restorative programs for about one year along side with getting therapy on and off. V2 reported R1 moves very slow and has a shuffled gait so R1 is a high fall risk. V2 stated the shuffling is a new development within the past four or five months and that is why therapy has been working with R1. V2 reported R1 walked with a normal gait before the shuffling began. V2 stated the DON is responsible for putting in interventions in the care plan for fall safety and educating staff on the interventions. V2 stated therapy worked with R1 before the falls but V2 denied being aware of any other interventions put

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| S9999 | Continued From page 3<br>in place before the fall on 8/16/24.<br><br>On 11/14/24 at 1:52PM, V3 (Nurse) stated R1 fell on the overnight shift, but was unable to remember a time. V3 reported checking on R1 around midnight and then one more time before the fall occurred, but could not remember the timeframe of when R1 was last check to the time R1 was found on the ground. V3 stated R1 was sleeping on both occasions during rounds before the fall. V3 reported the CNA (V4) told V3 that R1 fell. V3 stated R1 told V3 that R1 was getting out of bed while trying to use the bathroom. V3 stated this was not a witnessed fall. V3 reported R1 had a cut to the forehead and was sent out to the hospital. V3 stated at the time of the fall R1 could get up and walk around alone, but does have an unsteady gait. V3 was unsure if R1 is a high fall risk and could not state why R1 would be a high fall risk. V3 was unaware of R1 shuffling R1's feet when walking.<br><br>On 11/14/24 at 2:08PM, V4 (CNA) stated V4 was doing hourly checks and saw R1 on the floor and immediately went to tell the nurse. V4 reported R1 did have some bruises and a cut on the face and was sent to the hospital. V4 stated R1 was found on the ground around 3 or 4 AM. V4 reported checking on R1 around 11 PM and then one more time before R1 was found on the floor but was not able to give an exact timeframe. V4 stated R1 was a high fall risk at the time of the fall because does not walk normal and is not steady. V4 reported R1 is only supervision with assistance and does everything with without much help. V4 was unaware of any interventions put into place before the fall occurred due to the shuffling gate.<br><br>On 11/14/24 at 2:23PM, V5 (Director of Therapy) | S9999 | | |

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stated R1 was picked up on 6/28/24 for physical therapy. V5 reported R1 was referred because R1 presented with decreased standing balance and safety with ambulation. V5 reported R1 was at high risk for falls at the time R1 was admitted to therapy. V5 stated R1 also had occasional shuffling, and therapy worked with R1 so R1 could improve walking patterns and posture as well as increase lower extremity muscle strength. V5 stated R1 was discharged from therapy on 8/15/24 because R1 met R1's goals to the best of R1's ability and was referred to restorative. V5 reported restorative completes their own assessment to see what programs are appropriate. V5 stated R1 was picked up again on therapy on 8/22/24 for the same reasons that R1 was picked up in June. V5 stated R1 is a contact guard assist while, indicating someone should be physically touching R1, but, they are not doing any work. V5 reported staff hold R1 walking in case there is a loss of balance. V5 stated the therapy department is always in communication with staff at the facility to let them know what level the resident is at or what they need. V5 reported upon discharge the facility staff are made aware of any safety concerns with the residents.

On 11/14/24 at 2:56PM, V6 (DON) stated the CNA told V6 that R1 was found on the floor while doing rounds. V6 reported interviewing R1 and R1 told V6 that R1 was trying to go to the bathroom. V6 stated R1 is supervision with limited assist for some things. V6 was unable to specify what R1 needed more assistance with. V6 defined limited assist as needing more help and supervision means someone only needs to be watching. V6 reported after the fall on 8/16/24, staff educated R1 to call for assistance before getting up. V6 stated R1 was working with

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therapy around the time of this fall. V6 reported the fall was caused by R1's shuffling gait. V6 stated this shuffling has been occurring for about four or five months and is the reason R1 was referred to physical therapy. V6 reported putting in an intervention of physical therapy and notifying the physician about the shuffling. V6 stated any new interventions are put on the care plan and staff will be told verbally. V6 reported R1 was not a high fall risk at the time of the fall. V6 stated some risk factors to be considered a high fall risk would be previous falls, taking medication that can increase risk for falls, or any type of change that would affect ambulation. V6 denied putting in any other interventions because R1 "continued to ambulate at the same level."

On 11/14/24 at 3:09PM, V1 (Administrator) stated nursing completed the investigation for the falls. V1 reported R1 had a fall while getting up to the bathroom unassisted. V1 stated if there is any kind of changing condition, V1 would expect the staff to investigate and find out the reason why there is a change as well as put in interventions to prevent any falls.

On 11/15/24 at 10:26AM, V7 (Primary Physician) stated V7 vaguely remembered R1 had a fall and had some type of injury to the head requiring R1 be sent out to the hospital. V7 reported R1 does not walk normally and has some type of " knee problem or leg problem" but was unable to elaborate any further. V7 stated being aware there was a change in R1's gait, and R1 was referred to physical therapy but denied R1 needing any other fall interventions. V7 reported R1 was a fall risk, but not a high fall risk. When asked what makes a resident a high fall risk, V7 stated problems with walking or an abnormal gait can make someone a high fall risk. V7 reported

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the gait issue is why R1 was referred to therapy, but no other interventions were needed to prevent falls.

The Physical Therapy Evaluation dated 6/28/24 documents R1 was referred to therapy due to new onset shuffle in walking and decrease in lower extremity strength.

The Fall Scale dated 7/5/24 documents a total score of 15, indicating R1 is at low risk for falls. Anything higher than a 24 indicates a resident is at high-risk for falls. It is documented incorrectly that R1 has a normal gate. The shuffling of the gait was noted by staff sometime before R1 was referred to therapy on 6/28/24. There is no documentation in the nursing notes as to when the shuffling began.

The Physical Therapy Treatment note dated 8/5/24 documents R1 completed a session of physical therapy and is able to perform all functional tasks, however, R1 requires constant cuing for proper foot clearance during ambulation to avoid shuffling gait and increasing risk for falls.

The Physical Therapy Treatment note dated 8/9/24 documents R1 completed a session of physical therapy and tolerated treatments well with improved strength noted. R1 remains with shuffling gate during ambulation tasks.

The Follow Up Fall note dated 8/16/24 documents R1 experienced a fall and is able to ambulate independently without an assistive device. There is no documentation in this note that R1 has a shuffled gait.

The Fall Report dated 8/16/24 documents the CNA reported to the nurse that R1 fell in R1's

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room. R1 stated that R1 lost R1's balance while trying to use the bathroom. R1 has a small laceration on the right forehead. R1 was transferred to the hospital. No predisposing environmental or physiological factors are checked as contributing to the fall.

The Post Fall Observation dated 8/16/24 documents R1 fell on R1's room but this was not a witnessed fall. R1 reported trying to use the bathroom and slid to the floor. R1 was previously lying in bed prior to the fall. It is documented that R1 is able to ambulate independently without an assistive device.

R1 continued therapy after the fall on 8/16/24 and continued to show the shuffled gait was an issue when ambulating. The Occupational Therapy Treatment note dated 8/22/24 documents R1 is in the fall prevention group. R1 presents with shuffled walk and was instructed to pick up feet and take bigger steps with 100% carryover. R1 was observed with crossing feet and shuffling small steps when turning. R1 required consistent cues to ensure R1 was not crossing feet and taking bigger steps while turning in the bathroom.

The Final Investigation Fall Report dated 8/23/24 documents R1 sustained a small cut to the right forehead as a result of losing R1's balance and falling while walking to the bathroom. The incident was unwitnessed. The floor was checked and noted to be dry. R1 was wearing shoes at the time of the incident. Upon return from the hospital, R1 was placed on increase monitoring for safety. R1 was also counseled to seek assistance from staff as needed.

The Care Plan was reviewed and there is no documentation of R1 having a shuffling gait or a

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care plan and/or interventions addressing safety for the change in gait.

The Care Plan dated 8/29/24 documents R1 is at risk for falls due to having a fall on 8/16/24. The only intervention documented on this care plan is to educate R1 on using caution when ambulating and paying attention to surroundings.

The Minimum Data Set (MDS) Section GG dated 7/5/24 documents R1 needs supervision or touching assistance with all ADLs, bed mobility, transfers, and walking.

The policy titled, "Fall Program," dated 04/2020 documents, "All residents will be evaluated for falls. The following is the schedule for these evaluations: on admission/readmission, quarterly after admission, change in condition, and after a fall. Upon completion of the fall evaluation, if a resident is identified at risk for falls, the following may occur: a care plan is developed or updated, new fall interventions are reviewed with the resident and/or responsible and applicable staff, and education regarding the resident's risk of falls or interventions to prevent falls is provided."

(B)