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	IL6004741	A. BUILDING: _____ B. WING _____	C 10/31/2024

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S 000	Initial Comments Complaint and Facility Reported Incident Investigation 2498454/IL179454 Facility Reported Incident Investigation FRI of 9/27/24/IL179422	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210 d)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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including,	S9999		

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but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

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 interviews and record reviews, the facility failed to prevent or determine how an injury of unknown
origin occurred for 1 of 3 residents (R1) reviewed for resident injuries in a total sample of three. This failure resulted in R1 suffering an acute left femur fracture that was discovered at an outside ortho appointment.

Violations Include:

R1 is an 82 year old with the following diagnosis: fracture of the right femur, aftercare following joint replacement surgery, dementia, and vitamin D deficiency.

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R1 was unable to be interviewed due to no longer residing at the facility.

A Nursing note dated 9/27/24 at 11:20 AM documents R1 left the facility and went to the hospital for an appointment with an escort.

The Veteran Visit Summary dated 9/27/24 documents R1 was admitted to the hospital for a new hip fracture. An acute left hip fracture was noted on x-ray.

A Nursing note dated 9/27/24 at 7:25 PM documents the escort reported to the nurse that R1 was admitted to the hospital for evaluation. R1 was determined to have a left hip fracture.

The Hospital Records dated 9/27/24 document R1 presented to the ortho clinic today with a left hip fracture. R1 presented to the ortho clinic today for a follow up of a right hip arthroplasty that occurred in July 2024. R1 complained of left hip pain and was given a left hip x-ray which revealed an acute left femoral fracture. R1 had decreased mobility in the left hip joint also. R1 was admitted for possible surgical intervention.

On 10/29/24 at 10:17AM, V2 (R1 Family Member) stated staff notified V2 of R1 falling in 08/2024 but denied R1 having any injuries. V2 reported R1 went to a follow up ortho appointment at the end of September where a new left hip fracture was identified via x-ray. V2 stated R1 now is wheelchair bound after not having another surgery because it was too risky.

On 10/29/24 at 1:07PM, V4 (Nurse) stated R1 had a history of falling and was a high fall risk. V4 reported R1 had a hip fracture, but V4 did not

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know how R1 fractured R1's left hip. V4 was not able to answer what protocols the facility has in place when a root cause to a fall cannot be determined. V4 stated an injury of unknown origin is when someone gets injured but staff can't say how it happened.

On 10/29/24 at 1:23PM, V5 (Nurse) stated V5 sent R1 out to a follow up ortho appointment and R1 did not return to the facility. V5 reported R1 did have a fracture but V5 did not remember where the fracture was. V5 stated R1 did have numerous falls in August but was unable to say how many. V5 denied being aware of R1 having any falls near the time when R1 was sent out to the ortho appointment. V5 reported R1's last fall was at the end of August and R1 did not have any injuries. V5 was not able to define an injury of unknown origin. The surveyor then defined an injury of unknown origin to V5. V5 stated the new fracture would be an injury of unknown origin due to the facility not being able to identify a cause.

On 10/29/24 at 4:03PM, V8 (Former Nurse) stated R1 had more than three falls while residing at the facility but R1 did not suffered any injuries from the falls. V8 reported R1 was a high fall risk due to being confused and an unsteady gait. V8 denied knowing what an injury of unknown origin is. The surveyor then defined injury of unknown origin and V8 stated the new fracture should be considered and injury of unknown origin due to not being able to find a cause.

On 10/30/24 at 12:04PM, V10 (Restorative/Fall Nurse) stated R1 was a high fall risk on admission due to unsteady gait. V10 denied being aware of any injuries with any falls. V10 denied having any record of R1 falling in September. V10 reported being notified R1 had a new fracture

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during a morning meeting. V10 stated staff try to determine a root cause of each fall but they weren't able to determine a caused of the fracture. V10 reported a fracture would be a serious major injury. V10 stated managements talks to staff to see who was the last person to see R1 and establish how the fall occurred to the best of their ability what happened. V10 stated in this case there was nothing to say how R1 got the hip fracture and it can be classified as an injury of unknown origin.

On 10/30/24 at 2:34PM, V11 (CNA) stated V11 escorted R1 to the ortho appointment and no accidents occurred during transport. V11 reported after R1 took x-rays, V11 was told by hospital staff that R1 would be admitted to the hospital. V11 denied being aware of any new fracture.

On 10/30/24 at 2:45PM, V12 (DON) stated during the investigation, it seemed as though an accident happened when R1 was out on pass with family because R1 didn't have any falls in September. V12 reported R1 came back from the visit with pain but it was not investigated further. V12 stated the fracture cause was not able to be determined during the investigation.

The Hospital Admission Records dated 7/24/24 documents R1 admitted to the hospital after falling and breaking the right hip and femur. R1 is alert and oriented times one. The plan is to discharge R1 to a rehab facility.

A Nursing note dated 8/1/24 documents a loud noise was coming from R1's room and staff found R1 on R1's knees. R1 admitted to trying to walk. R1 was assessed in an abrasion to the left knee was found. An x-ray of the knee was performed and was negative. No other injuries were noted.

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A Nursing note dated 8/18/24 documents R1 fell and a head to toe assessment was completed with no apparent injury noted. R1 was able to move all extremities.

A Nursing note dated 8/22/24 documents R1 attempted to stand on assisted and walk back to the wheelchair and fell. A head to toe assessment was completed and no major injuries were noted. R1 sustained minor skin tear to the right knee with minimal bleeding. R1 was able to move all extremities.

A Nursing note dated 8/25/24 documents R1 was noted on the floor across the hall from our room. R1 was laying on the right side and had redness to the lower back. When asked what happened, R1 replied that R1 walked over to the other room. R1 complained of low back pain and medication was given. The physician ordered to send R1 out to the hospital for evaluation. R1 returned back to the facility with no new orders. The x-ray results were negative.

The Hospital Records dated 8/25/24 document R1 presented to the emergency department after an unwitnessed fall. R1 is alert and oriented times one at baseline. An X-ray of the pelvis was completed. A right hip arthroplasty was noted to be in alignment. No other fractures in the right or left hip or noted at this time. R1 was sent back to the facility.

A Nursing note dated 9/5/24 at 11:15 AM documents R1 went out on pass with family and left and stable condition. R1 is due to return tonight.

A Nursing 9/5/24 at 6:15PM documents R1

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returned from being out on pass with family. R1 complained of pain all over R1's body. R1 denied falling and denied being bumped. R1's family was called and asked if anything happened while out on pass and the family denied any injuries.

The Medication Administration Record dated 09/2024 documents R1 rated pain a 10 out of 10 and was given Tylenol. The pain assessment scores were reviewed and documented as zero for each entry. The complaint of pain on 9/5/24 after returning from an outside pass is new onset pain. No complete pain assessment or further assessment of the pain was documented after the medication administration. The physician was also not notified of the new onset pain.

The Minimum Data Set (MDS) dated 8/1/24 documents a Brief Interview for Mental Status score as a five (severe cognitive impairment). Section GG of the MDS documents R1 has an impairment to one lower extremity and uses a wheelchair as a mobility device. R1 is a substantial/maximal assist with most ADL care. R1 is a supervision or touching assist with bed mobility and a partial/moderate assist with transfers. Walking was not attempted during this assessment.

The Facility Unusual Occurrence 24 Hour Report Form dated 10/3/24 documents R1 went to the hospital for an ortho. Follow up appointment. X-rays were completed at the appointment and a left hip fracture was noted. R1 is alert and oriented times one with confusion. Before the appointment, R1 showed no signs of pain or discomfort. R1 had no new redness, bruising, deformities, or changes in behavior. Upon investigation, no report or knowledge of any falls or other incidents or noted. At this time, the cause

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S9999	Continued From page 7 of the injury is unable to be determined. R1 remains in the hospital. Based off the progress notes, R1 has an extensive history of falls and a new onset of pain on 9/5/24 that had was never further assessed nor was a physician notified. The facility was unable conclude when or how an injury occurred. ' Since R1 had an x-ray of the pelvis on 8/25/24 that was negative, the injury had to occur some time fro 8/26/24 to 9/27/24 when the injury was discovered. The policy titled, "Abuse Prevention Program Facility Policy," dated 2012 documents, " ...An injury should be classified as an "injury of unknown source" when both of the following conditions are met: The source of the injury was no observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because the extent of the injury of the location of the injury." (A)	S9999		