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S 000	Initial Comments Facility Reported Incident of 10/13/24/IL179721	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 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 includes measurable objectives and timetables to	S9999		

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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.

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.

These Requirements were not met evidenced by:

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Based on observation, interview, and record review the facility failed to ensure residents were transferred in a safe manner for 2 of 3 residents (R1, R2) reviewed for safety in the sample of 5. This failure resulted in R1 sustaining a right femur fracture and R2 sustaining a laceration requiring 21 sutures.

The findings include:

1. The facility's Incident Report dated 10/13/24 shows "R1 is an 86 year old male resident who resides at the facility for long term care services since 8/13/18. On 10/13/24, at approximately 5:30 PM, staff were assisting resident with bed linen change. Resident was sitting at the side of the bed and staff was going to stand him at bedside to adjust his pants when resident attempted to self transfer to the wheelchair. Resident's legs crossed causing him to fall to the floor onto his right side. Assessment completed with external rotation, shortening and deformity observed to upper right leg. Hospice, Power of Attorney, and Physician notified with orders to send to the emergency room for further evaluation. Notified by emergency room that resident admitted with a diagnosis of right hip fracture."

On 11/4/24 at 9:25 AM, V3 Licensed Practical Nurse said R1 is a frequent faller and will transfer himself to bed without waiting for staff. V3 said R1 is alert and oriented to person, is impulsive, and can stand with a gait belt and one assist with frequent cueing. V3 said she was called into R1's room by the Certified Nursing Assistant (CNA) and found R1 on the floor on his right side with his legs under the bed. V3 said R1 kept trying to pull himself up and would not be still so she could assess him. V3 said R1 was saying "Ouch," but

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would not say where the pain was. V3 said she was unable to assess R1 on the floor and was afraid R1 was going to hurt himself more trying to pull himself up, so herself and V4 and V5 CNA transferred him to bed. V3 said when R1 was in bed, she noticed R1's right leg was rotated out and was shortened. V3 said R1 was saying "Ouch my leg." V3 said at the time of the fall, V4 and V5 were getting R1 up for supper and R1 was sitting on the side of bed with his pants down around his ankles. V3 stated "you always use a gait belt for transfer so you don't hurt their arms by using them to help stand. In this case, they didn't even have pants to grab onto to." V3 said R1 had his shoes on, an incontinence brief, and his pants were down at his ankles. V3 said R1 did not have a gait belt on. V3 said R1 was sent to the emergency room and had a right hip fracture. V3 said R1 returned to the facility with continued hospice and expired at the facility.

On 11/4/24 at 9:38 AM, V4 CNA said she was getting R1 up for dinner at the time of the fall. V4 said R1 was wobbly and anxious that day so she asked V5 CNA for help getting him up. V4 said they had rolled him in bed, changed his linens and his brief, and assisted R1 to sit at bedside. V4 said R1 was sitting with his legs crossed and his pants down at his ankles. V4 said V5 was on the opposite side of the bed and she was next to R1 getting the wheelchair in position. V4 said R1 tried to stand by himself and his right hand reached for the wheelchair which moved (was not locked due to not in position yet) and R1 fell forward onto the floor on his right side. V4 said R1 kept saying "ouch," but was moving around on the floor. V4 said she sent V5 to get the nurse. V4 said R1 didn't have a gait belt on, the plan was to hold R1 by the pants to transfer him.

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On 11/4/24, V5 was attempted to be reached via phone two times and messages left, with no return call.

The facility's Incident Staff Statement from V5 shows "R1 stood up with pants down without support, slipped on pants and fell criss-cross on his right leg. I heard him scream "ow my leg" repeatedly."

R1's Progress Note dated 10/13/24 shows "called to room by CNA and observed resident sitting on the floor with legs crossed under the bed facing the doorway. Resident was attempting to get up form floor independently and would not follow request to wait until assessment was completed. When asked what happened resident stated, I fell. Assist resident into bed, assessment completed, noted external rotation, shortening, and deformity noted to upper right leg no other injuries observed.

On 11/4/24 at 10:01 AM, V2 Assistant Director of Nursing said R1 had poor safety awareness, was cognitively impaired, and was impulsive. V2 said R1 transferred via stand pivot with one assist to the wheelchair. V2 said staff are supposed to use a gait belt for transfers per the facility policy and for safety. V2 said the gait belt helps with stability and helps staff have some control during the transfer and staff can hold the gait belt to lower the resident to the floor during a fall. V2 said after speaking with the staff, R1 was sitting at the bedside and before staff was able to assist, R1 attempted to stand but has his legs crossed and fell to the right onto the floor. V2 said at the time, R1 did not have a gait belt on.

On 11/4/24 at 2:05 PM, V10 Nurse Practitioner said R1 had progressing dementia and was on

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hospice at the time of his fall. V10 said resident's Care Plans and facility policy should be followed when transferring residents.

R1's Fall Risk Screen dated 10/8/24 shows R1 is at high risk for falls due to history of multiple falls and R1 exhibits loss of balance while standing.

R1's Hospital After Visit Summary shows R1 has a periprosthetic fracture of proximal end of right femur.

R1's Care Plan shows R1 is at risk for injury from falls related to unsteady gait, reduced strength, poor decision making related to dementia. The same Care Plan shows R1 is a restorative program for ambulation with interventions to give verbal cues and assistance to don gait belt, stand upright and avoid leaning, and stand using a wide support base.

The facility's undated Safe Resident Policy shows "Gait belt usage is mandatory for all residents handling with the exception of bed mobility and medical contraindications.

2. On 11/4/24 at 12:10 PM, R2 was sitting at the dining room table with her husband V11. R2 had visible blood crusted sutures along her hair line extending from the middle toward the right side. R2 had yellowish colored bruising on her right to middle forehead and some purple/red colored bruising under her right eye. R2's left arm was in a brace. V11 said R2 has 21 sutures from her fall on 10/31/24. R2 nodded and touched her hairline and continued eating. V11 said that day it was so windy, there was 50 mph wind gusts and R2 had a doctor appointment. V11 said they were coming down the sidewalk of the facility to the van and there is a slope in the sidewalk after

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going around the flagpole to go down to get to the ramp of the van. V11 said the slope of the sidewalk made the wheelchair lean forward a bit and R2 fell forward out of the wheelchair onto the ramp of the van. V11 said he was at the back of the wheelchair and there was the van driver trying to get R2's wheelchair down the slope of the sidewalk and onto the ramp. V11 said the sidewalk goes around the flag pole area and then slopes down sharply to meet the sloped area of the sidewalk going into the drive. V11 said there are better areas of the sidewalk to load a wheelchair from where the slope is less steep and you don't have to maneuver around the flagpole. V11 said there was only one staff member and himself trying to get R2 onto the van.

On 11/4/24 at 12:18 PM, this surveyor observed the facility sidewalk leading from the entrance to the driveway of facility. The sidewalk from the facility entrance leads perpendicular to the driveway. There is a sidewalk that runs along side the driveway and intersects with the entrance sidewalk. At the intersection there is a triangular flower bed with a flag pole in the center. In order to reach the sloped area from the sidewalk into the driveway, you have to walk around the flag pole area and go down a sharp incline to then reach the sloped area of the sidewalk going down to the driveway. A wheelchair would have to go left or right around the flag pole, propel forward (parallel to the driveway) go down the sharp incline, then turn perpendicular to the driveway to go down the slope in the sidewalk that connects with the driveway.

On 11/4/24 at 10:01 AM, V2 Assistant Director of Nursing said she was in the administrators office by the facility entrance when staff came and told

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her a resident had fallen outside. V2 said she ran outside and found R2 on the ground with her face on the wheelchair ramp of the transport van. V2 said V11 told her R2 had leaned forward and fell out of the wheelchair. V2 said she could see blood pooling but could not tell where it was coming from and didn't want R2 to move. V2 said V10 Nurse Practitioner had also come outside and was helping stabilize R2's head and hold pressure. V2 said it was extremely windy and started to pour down rain on them. V2 said V11 was propelling R2 in the wheelchair up until V7 Activity Aid took over at some point. V2 said there is a dip in the sidewalk leading to the slope of sidewalk where the wheelchair lift of the van was.

On 11/4/24 at 12:26 PM, V7 said she is the driver of the van that takes residents to appointments. V7 said she is an activity aid and is not a CNA. V7 said V11 pushed R2 in her wheelchair from the front door, down the sidewalk, around the flag pole and down the sidewalk incline to the sloped area of the sidewalk leading to the driveway. V7 said she took over pushing R2 and then R2 leaned forward and fell out of the wheelchair. V7 said it was very windy that day and almost immediately started pouring when R2 fell. V7 said there was no other staff that assisted her that day. V7 said she should have asked someone to come along since it was so windy. V7 said R2 did not have any foot pedals on her wheelchair and had her left arm in a brace so was not able to stop herself when she was falling forward.

On 11/4/24 at 1:12 PM, V8 Restorative Aid said R2's left arm is broken and is in a brace so R2 can't propel herself and can't stand without staff assistance. V8 said she issues foot pedals to all

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new residents. V8 said R2 should have had foot pedals on since R2 can't propel or stabilize herself in the wheelchair. V8 said she got R2 up for the day and took her to therapy. V8 said she didn't put foot pedals on R2's wheelchair at that time. V8 said after therapy, R2 went to breakfast and then was leaving to go to a doctors appointment. V8 said she was not R2's CNA that day, and had just helped by getting her up that morning. V8 said she was not sure if R2 left for the appointment with her foot pedals on the wheelchair.

On 11/4/24 at 1:15 PM, V9 Nurse Practitioner said R2 is so fearful of falling and is not able to stand for any significant amount of time. V9 said R2 had Parkinson's and has an elbow fracture from a fall at home. V9 said R2's left arm is in a brace and R2 has generalized weakness and unsteadiness due to Parkinson's V9 said R2 has no ability to stop herself from falling forward from the wheelchair.

On 11/4/24 at 1:32 PM, R2 was sitting up in her wheelchair in her room, there were no foot pedals on her wheelchair. R2 said when she fell, she was going downhill and leaned forward and couldn't stop herself from falling since her left arm was in a brace. R2 said she didn't have foot pedals on her wheelchair.

R2's Hospital After Visit Summary dated 10/31/24 shows "7 sutures place in galea (layer of scalp) and 14 sutures placed superficially.

The facility's Fall Report dated 10/31/24 shows V7 statement "I was transporting R2 to her doctor appointment today. It was approximately 10:20 AM. I was pulling the bus to the front door and R2 and V11 were waiting at the front door to

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come out the bus. I pulled up and and V11 started pushing R2 down the sidewalk towards the bus and when he got R2's wheelchair to the edge of the sidewalk/start of the wheelchair lift I was trying to turn R2's wheelchair so that I could put her wheelchair on the lift, but it was extremely windy causing problems turning R2 and V11 was in a rush to get her to her appointment. I went to push her onto the wheelchair ramp and she tipped forward and fell forward onto the ramp. I told V11 to get someone right away in the building."

R2's Care Plan shows R2 has diagnoses of muscle weakness (generalized), unsteadiness on feet, difficulty walking, Parkinson's disease with dyskinesia with fluctuations and injury of left elbow. The same Care Plan shows R2 has a hinged brace to her left arm related to a fracture, demonstrates a self-care deficit and requires assist with activities of daily living related to limited mobility and impaired balance, non-weight bearing to left upper extremity, needs assist of 2 for transfers. The Care Plan shows R2 has potential for falls and is at risk for injury from falls. The same Care Plan was updated after R2's fall on 10/31/24 with the intervention "staff to ensure resident foot pedals are on wheelchair prior to propelling resident, Ensure resident positioned properly in wheelchair."

R2's Occupational Therapy Evaluation and Plan of Treatment dated 9/24/24 shows R2 has impaired range of motion to her upper extremities and R2's sitting balance during activities of daily living is fair (reach to ipsilateral side and unable to weight shift). "Clinical Impressions: Patient presents with reduced functional activity tolerance, balance and strength affecting safety, ease and independence with activities of daily

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S9999	Continued From page 10 living and functional mobility. Risk factors: Due to the documented physical impairments and associated functional deficits the patient is at risk for falls, further decline in function and increase dependency upon caregivers." (A)	S9999		