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S 000	Initial Comments Facility Reported Incident of 8/23/24/IL179214	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)3)6) 300.1220b)3) 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. 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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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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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.

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

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modified in keeping with the care needed as indicated by the resident's condition.

These requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed perform assessments, failed to continue to monitor a resident's change of condition, failed to communicate changes in a resident's condition, and failed to provide treatment of a fracture in a timely manner for 1 of 3 residents (R1) reviewed for quality of care in the sample of 7. These failures resulted in experiencing continued pain after a fall on 8/23/24 and a delay in her being sent to the hospital for evaluation and treatment. R1 was transferred to the hospital on 9/5/24 (2 weeks after she fell) and sustained a right hip fracture that required surgical repair of the fracture.

The findings include:

On 11/6/24 at 10:44 AM, R1 was lying in bed. R1 said there were two CNAs (Certified Nursing Aides) putting her back to bed, after lunch (on 8/23/24). R1 said the wheelchair was parked, facing the bed, near the middle of the bed. R1 said the CNAs applied the sling under her arm, she held onto the grab bar, and they used the lift to stand her up. R1 stated, "I don't know what the problem was, but they were taking too long, and I told them I couldn't stand anymore. They pushed the lift over near the bed, but my legs weren't against the bed. They were trying to take of my pants, so I could lay down. It was taking too long, and I told them. Then my legs just gave out. I was hanging there, by my arms. The sling was pulling under my armpits and shoulder, and I was hanging on to the handles. They tried to sit me on

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the edge of the bed, but I was slipping. I landed on my butt on the floor. My right arm was sore right away and later on my right hip stated to really hurt." R1 said a nurse did not complete a head to toe assessment after she fell. R1 said the CNAs used the total lift to get her back in bed without the nurse checking her first. R1 said the facility did X-rays a couple days after she fell, but they told her there wasn't a fracture. R1 said she was having hip pain for two weeks before she was sent to the hospital. R1 said she had to have her hip repaired surgically. R1 said she wasn't able to do her regular therapy because her right hip was hurting too bad. R1 said she tried the sit to stand one more time, but it hurt so bad, and they had to stop. R1 said after that, she only did therapy in her bed, and it hurt when she did the leg exercises. R1 stated, "I think someone made a mistake. I don't like to think about the fall. It was such an awful experience. I was just hanging from that sit to stand lift, by my arms for a long time and then I fell on my butt".

On 11/6/24 at 2:59 PM, V20 (CNA) said R1 was in the wheelchair, and we were trying to get her back to bed, after lunch. V20 said V19 (CNA) was helping her. V20 said R1 was seated in the wheelchair, the sling was placed under her arms, and they started to use the sit to stand lift to raise R1's bottom out of the wheelchair. V20 said they were having difficulty with R1's wheelchair being in the way and the transfer was taking a little longer than usual. V20 said R1 can't stand on the sit to stand platform very long. V20 said they moved R1 toward the bed as fast as they could, but R1's right side gave out. V20 said R1 is a large lady and part of her bottom was on the bed. V20 said she was managing the lift and from where she was standing, she thought R1 was on the edge of the bed. V20 said V19 told her that

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she was trying to hold the resident in place with her knee and she needed to get help. V20 said she ran to the hall for help. V20 stated, "It was chaos. Everyone was busy" V20 said R1 was hanging from the sit to stand lift by her arms, with her hands still holding on to the hand grips, and her arm stretched over her head. V20 said R1 was hanging like that for a couple of minutes. V20 said V21 (CNA) came to help. V20 said V19 (CNA) was on R1's right side, using her knee to wedge R1 into the bed and keep her from slipping, but it was getting too hard, and they had to lower her to the floor. V20 said R1 just slipped to the floor. V20 said R1 still was holding onto the handles, the sling was still attached to the lift, and R1's bottom was on the floor. V20 said they didn't think it was a fall because she "slipped from the bed to the floor." V20 said they removed R1's sit to stand sling and used a sling to lift R1 off the floor and back into bed. V20 did not report the fall to the nurse immediately and the nurse did not assess R1 before she was removed from the floor. V20 said she didn't work for a couple weeks after R1's fall.

On 11/6/24 at 3:46 PM, V19 (CNA) said she was the CNA helping V20 transfer R1 to bed on 8/23/24. V19 said they were transferring R1 from her wheelchair to bed and tried to change her incontinence brief before sitting her down on the edge of the bed. V19 said R1 said she couldn't hold herself up any longer, her legs went week, and she collapsed. V19 said she placed her knee behind R1 to try to keep her from sliding off the bed. V19 said some of her bottom was on the bed, but not all of it. V19 said she told V20 to get help because she couldn't hold R1 for long, her knee was starting to hurt. V19 said V20 thought we could "push" R1 into the bed, but I told her that wouldn't work, and we needed help. V19

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stated, "[V20] left the room to go get help. I don't how long she was gone but felt like a long time. I told [R1] we were going to have to lower her to the floor because my knee was hurting. We lowered her to a seated position on the floor. One of her legs was in an awkward position. It was a little twisted. I don't remember which one. She seemed scared because we got scared. She was complaining of pain, but I don't remember exactly what she said. She was hanging from the lift for quite a while. All of it was so sudden. She said, "I can't, my feet." By the time [V20 and V21 (CNAs)] came back in the room, I was already lowering R1 to the floor. [V20] and I got the total lift, and we got her back to bed. The nurse didn't come in and assess her before we got her back to bed. [V20] and we got write ups for this. I was surprised the nurse didn't come. [V20] said the nurse isn't coming because she's pregnant. I know we shouldn't have gotten her up until the nurse assessed her."

R1's Facesheet dated 11/6/24 showed diagnoses to include, but not limited to: right hip fracture and orthopedic aftercare (9/9/24); CHF (Congestive Heart Failure); COPD (Chronic Obstructive Pulmonary Disease); peripheral venous insufficiency; stroke with right sided weakness; major depressive disorder; morbid obesity; lymphedema; GERD (Gastro-Esophageal Reflux Disease); chronic pain syndrome; pain in right shoulder and right hip (9/9/24); reduced mobility; unsteadiness on feet; generalized muscle weakness; lack of coordination; and need for assistance with personal care.

R1's facility assessment dated 7/30/24 showed she was cognitively intact; and was dependent on staff for toileting, shower/bathing, and transfers.

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R1's Progress Notes and Assessments were reviewed for 8/23/24. There were no notes or assessments (vital signs, neuro checks, ROM, pain, skin check) completed by R1's nurse (V18 - Agency RN). There were late entries created on 8/30/24 by V2 (DON - Director of Nursing) and V30 (MDS Coordinator). R1's Post Fall Evaluation dated 8/23/24 showed R1 had a witnessed fall in her room when she was being transferred to bed with a sit to stand mechanical lift, by V19 and V20 (CNAs).

R1's Progress Note dated 8/25/24 showed, "Resident complained of pain with ROM (Range of Motion) to right shoulder, right hip, and right lower extremity..." The doctor was notified and orders for X-rays were obtained. (This note was 2 days after R1's fall).

R1's portable Right hip X-ray report 8/25/24 showed there was no fracture or dislocation seen and she had moderate degenerative changes.

R1's Health Status Note dated 9/5/24 showed R1 continued to complain of right hip pain after a fall on 8/23/24. The doctor was notified, and orders were received to send R1 to the hospital. R1's progress notes do not show continued assessments of R1 after her fall. R1's notes do not reflect that she was unable to bear weight in therapy, could no longer use the sit to stand lift, had pain with ROM/exercises with right leg, and was complaining of right hip pain from 8/25/24 until 9/5/24 (when she was sent to the hospital for "continued right hip pain" after a fall on 8/23/24.)

R1's August and September 2024 MARs showed R1 took Norco (opioid pain medication) 5-325 mg 1 tablet 2-4 times a day for pain rated "3-9" on a 1-10 scale.

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R1's Occupation Therapy Notes dated 8/23/24 (before she fell) showed R1 was currently using the sit to stand machine for lifts and was completing tasks to increase her upper arm strength. On 8/26/24 R1's notes showed the therapist discussed attempting to get R1 up with a sit to stand lift tomorrow and R1 said she would try and wanted to work towards using the sit to stand again. R1's note on 8/27/24 showed she was a total lift transfer.

R1's Physical Therapy Discharge Summary dated 5/20/24 to 9/6/24 showed R1's prior equipment was a sit to stand lift and wheelchair. This summary showed R1 was discharged to the hospital. This note showed, "...Progress & Response to Treatment: The patient had been demonstrating good stability on the sit to stand lift for functional transfers but had fallen off the lift when transferring with the CNAs in her room. Patient had been complaining of RLE (right lower extremity) pain, was admitted to the hospital..."

R1's Physical Therapy Recertification, Progress Report and Updated Therapy Plan dated 8/20/24 to 9/29/24 showed R1 was able to perform bed to wheelchair transfers with sit to stand lift with good stability but required more skilled therapy to ensure safety on sit to stand lift and to trial toilet transfers with sit to stand lift for safety. R1's Physical Therapy Progress notes dated 8/22/24 (before she fell) showed she performed a sit to stand from the bed to the wheelchair and the wheelchair to the bathroom. R1's Physical Therapy notes do not include R1's sit to stand performance after the fall on 8/23/24.

R1's Orthopedic Pre-operative Report dated 9/8/24 showed R1 had a surgical nailing of her

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right hip to repair the fracture. This note showed R1 fell at the nursing home 2 weeks ago and continues to have pain in her right hip and inability to perform ADLs (Activities of daily living) including sitting to stand and stand to sit. The document showed, "... The X-rays at the time of the nursing home showed a minimally displaced greater trochanteric hip fracture. The patient was then admitted to the hospital for continued right hip pain in order to get an MRI of the right hip. MRI of the right hip was done yesterday (9/7/24) which showed a greater trochanteric hip fracture with intertrochanteric extension to greater than 50% of the intertrochanteric region. The fracture was due to a combination of trauma from a fall and pathologic bone due to osteoporosis..."

On 11/7/24 at 12:01 PM, V18 (Agency RN) said she was R1's nurse on 8/23/24 but she had no idea R1 fell. V18 said the CNAs didn't tell her R1 fell. V18 said she was charting at the nurses' station, and she was approached by therapy. V18 said therapy reported that R1 had a "rough transfer." V18 said she went to R1's room about 30 minutes later. V18 said the CNAs were in R1's room and she asked if there was an incident. They said it was a "rough transfer." V18 said no one reported a fall to her, she didn't complete an assessment of R1 after the fall, and there wasn't any documentation because she wasn't aware R1 fell. V18 stated, "If I knew about a fall, then I would have started the assessments and paperwork immediately. If you're going to have a fall, a witnessed fall is the easier one to have. It's less paperwork. All R1 said was she didn't want to use the sit to stand anymore, she stated, "I don't want to do that again." Then I heard a few days later she told someone else she fell, and she was sent out to the hospital. V18 said she didn't take care of R1 again until she returned

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from the hospital after she had surgery on her broken hip.

On 11/7/24 at 9:55 AM, V23 (PTA - Physical Therapy Assistant) said prior to R1 falling, they had been working training with the sit to stand. V23 said a sit to stand lift was performed in the therapy gym successfully and he had completed in room training with the CNAs on sit to stand transfers for R1. V23 said R1 was doing well with the training and could bear weight for several minutes during the transfer. V23 said he was surprised when he heard there was a "rough transfer" on 8/23/24 (Friday). V23 said he saw R1 the following Monday or Tuesday and attempted the sit to stand lift and R1 could not bear weight. V23 said R1 complained of right hip pain and demanded to stop. V23 said he should have documented that in his notes. V23 said he didn't attempt the sit to stand lift with R1 again and after that her therapy consisted of exercises in the bed or wheelchair and the staff used a total lift for transfers. V23 said R1 often had pain with ROM and exercises with her right leg. V23 said he did not communicate R1's complaints of right hip pain with ROM/exercises and inability to bear weight to the nursing staff. V23 stated, "I thought since the X-ray didn't show a fracture that her pain would eventually go away. I was under the assumption that the nurses' knew about her right hip pain. That's my fault. I thought they knew, but I should have told them. She was doing pretty good with the sit to stand transfers before the incident, but after the failed sit to stand attempt, her therapy consisted of more seated or in the bed exercises due to her pain in the right leg."

On 11/7/24 at 8:38 AM, V21 (CNA) said she was providing care to another resident when V20 said they needed help in R1's room. V21 said when

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she went in the room, V19 had her knee underneath R1 and R1 was hanging from the sit to stand lift. V21 stated, "There's no way [V19] could have held R1 for long." V21 said she and V20 help lower R1 to the floor. V21 said she left R1's room after that. V21 said when a resident falls the nurse should be notified right away. V21 said the nurse does an assessment and tells us if it's safe to transfer the resident. V21 said we don't want to hurt the resident if they have injuries already.

On 11/7/24 at 11:03 AM, V26 (RN - Registered Nurse) said she was familiar with R1 and verified that she had worked R1's hallway between 8/23/24 (R1's fall) and 9/5/24 (R1's transfer to hospital - 2 weeks later). V26 said R1 was alert and oriented. V26 said R1 had chronic issues of pain and had complained of hip pain occasionally. V26 said she gave R1 Norco and tried to stay on top of her pain. V26 said she was not aware that R1 was not able to bear weight in therapy and was having right hip pain with movement of her right leg. V26 stated, "They don't always tell us stuff. If I knew R1 fell and she was having those problems, I'd assume her hip was broken and call the doctor to send her to the hospital as soon as possible. But no one told me that".

On 11/7/24 at 8:54 AM, V22 (RN) said she was working 9/5/24 (when R1 was sent to the hospital). V22 said she was not assigned to R1 but was the supervisor working that day. V22 said V25 (R1's nurse) came to her because she didn't know what to do. V22 said V25 reported R1 had a fall on 8/23/24 and was complaining of right hip pain rated at a 10 on a 1-10 scale. V22 said she told her to call the nurse and helped call 911. V22 said that's why she entered a note on 9/5/24. V22 said if a resident had a fall and is complaining of

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severe hip pain, they need to be sent out as soon as possible because there may be a fracture.

On 11/7/24 at 1:02 PM, V2 (DON) said she was at the facility on 8/23/24. V2 said she didn't witness R1's fall, was not in R1's room after the fall and didn't not complete an assessment on R1 on 8/23/24. V2 said the CNAs did not report a fall. V2 said she was in the hall and overheard V19 talking. V2 said V19 reported a "rough transfer," but not a fall. V2 said she didn't ask any other questions and went to deal with another issue. V2 said on 8/25/24 she got a call from V1 (Administrator). V2 said she was told R1 was having pain "all over," and was asked if there had been an incident. V2 stated, "I told her that I heard there was a rough transfer but wasn't aware of an incident. She (V1) said [R1] did go on the floor and that's considered a fall. They got orders for X-rays. I didn't come in that day or do an assessment. The nurses should be documenting a fall and their assessment in the progress notes. The purpose is to ensure there is continuity of care and communicate with other staff what has been happening with the resident. On 8/30/24 we had a fall meeting and were reviewed R1's documentation and realized there was no charting on 8/23/24 about the fall." V2 said, "If a resident is complaining of pain with ROM after falling, then the resident shouldn't be moved and sent out 911 to the hospital. I don't have X-ray vision. I can't tell if there is a fracture by looking at them. The nurses should have charted all of that information, but the CNAs didn't report a fall." V2 said the nurses should have performed and documented continued assessments of R1 after she fell to ensure there wasn't an injury. V2 said she was not aware that R1 was having pain with movement of the right leg and was no longer able to bear weight. V2

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	IL6004253	A. BUILDING: _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF MENDOTA	1201 FIRST AVENUE MENDOTA, IL 61342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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said therapy did not report that to her. V2 said if she had known, then she would have sent R1 out to the hospital sooner for further evaluation. V2 said R1's progress notes and assessments should reflect a timeline of R1's injuries and complaints. V2 said R1's progress notes did not contain the pertinent nursing assessments to demonstrate a thorough assessment. V2 said the purpose of continued assessments, documentation of findings, and interdisciplinary communication of resident's change of condition is to ensure the resident is receiving proper care and continuity of care can be maintained.

On 11/7/24 at 11:26 PM, V27 (NP - Nurse Practitioner) said she is familiar with R1 and took care of her before she was admitted to the facility. V27 said she would expect the staff to complete a head to toe assessment after a fall, continued assessments of the resident, and to document their assessments. V27 said the nurses will notify her or the physician of falls. V27 said if there is an injury then they call right away, but if not, injury they may send a message. V27 said she wasn't sure when she was notified of R1's fall. V27 said she doesn't document her phone communication with the facility. V27 stated, "The facility is responsible for maintaining that documentation." V27 said she had not done an assessment on R1 between 8/23/24 - 9/5/24. V27 said she expects the staff to perform and assessment and notify her of any changes in the resident condition. V27 said she isn't an orthopedic doctor, but inability to bear weight, increased pain upon palpation of the right hip area, or increased pain with movement of the right leg could be indications of a fracture. V27 said she would expect the staff to notify her immediately with these symptoms, so the resident can be transferred to the hospital for further evaluation. V27 said it's possible that R1's fall on

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8/23/24 contributed to her right hip fracture, but she was not an orthopedic doctor.

On 11/7/24 at 3:08 PM, V28 (Orthopedic Surgeon) said it's very likely that the initial portable X-ray completed on 8/25/24 did not capture the fracture due to R1's body size and positioning with portable X-ray machines. V28 said an MRI would be needed for more sensitive results. V28 said inability to bear weight, pain in the hip area, or pain with ROM/movement of the affected limb are signs of a fracture. V28 said the facility should report these concerns to the physician and obtain an order to send the resident to the hospital for further evaluation. V28 said he wasn't clear how R1 fell. The surveyor explained the fall from the sit to stand lift. V28 replied, "It's very likely that caused her fracture, and the original X-ray missed it. If she was complaining of continued pain and hadn't returned to baseline physical functioning, they should have sent her to the hospital. She ended up having surgery to repair her hip. The pain she was having was likely from the fracture and she needed stabilization (surgery) on her hip to reduce the pain."

The facility's undated Safe Resident Handling/Transfers Policy showed, "It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure, and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines..."

The facility's undated Fall Prevention Program showed, "Each resident will be assessed for fall risk and will receive care and services in

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S9999	Continued From page 14 accordance with their individualized level of risk to minimize the likelihood of falls. Definitions: A "fall" is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force (e.g. resident pushes another resident). The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere... 9. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury." The facility's undated Fall Checklist showed, "#1. Complete assessment/VS, initial neuro checks as indicated. If any injury noted or suspected keep resident still and do not transfer to bed or chair. Contact 911 and send to ED for evaluation and treat..." (A)	S9999		