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S 000	Initial Comments Investigation of Facility Reported Incident of September 20, 2024/IL179736 Investigation of Facility Reported Incident of September 16, 2024/IL179714 Investigation of Facility Reported Incident of October 4, 2024/IL179878 Investigation of Facility Reported Incident of September 28, 2024/IL179877- No findings.	S 000		
S9999	Final Observations Statement of Licensure Violations 330.710a) 330.780a) 330.780b) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. Section 330.780 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any	S9999		

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serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

This REQUIREMENT is not met as evidenced by:

Based on interviews and record reviews, the facility failed to follow its fall prevention policy by not implementing effective fall interventions and accurately assessing a resident's fall risk for three residents (R1, R2, and R4) out of four residents reviewed for falls in a sample of 4. These failures resulted in R1 sustaining a laceration to left forehead requiring 5 sutures after a preventable fall on 9/15/24; R2 sustaining a laceration above right eyebrow requiring 6 sutures after an unwitnessed fall on 10/4/24; and R4 sustaining swelling and bruising to the right side of forehead requiring hospitalization on 9/20/24 and 9/21/24.

Findings include:

On 11/23/24 at 2:15PM, V5 (Licensed Practical Nurse/LPN) was interviewed regarding resident falls. When questioned about R1's fall on 9/15/24, V5 stated that she did not know what happened. When questioned the location of R1's injury and sutures, V5 responded maybe his forehead. When questioned about R2's fall on 10/4/24, V5 stated that maybe she rolled out of bed. When questioned the location of R2's injury and sutures, V5 responded maybe her forehead. When questioned about R4's fall on 9/20/24, V5 stated that she did not know what happened.

On 11/25/24 at 1:30PM, V1 (Executive Director) stated that she started working at this facility in June 2024. V1 stated that she was not aware that a negotiated risk form should be completed per this facility's falls prevention policy until this

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surveyor requested copies of R1, R2, and R4's forms. V1 stated that residents' service plans were not kept up to date prior to her starting here. V1 stated that moving forward all residents will have a service plan initiated upon admission and updated as needed. V1 stated that the nurses should communicate with each other if a resident has a fall so the resident can be monitored for 72 hours post fall.

1. On 11/25/24 at 10:06AM, V2 (Administrative Services Coordinator) stated that fall precautions implemented after R1's fall included increase rounding and assist with toileting. V2 stated that the caregivers were present in R1's room at time of fall. V2 stated that V2 is unsure if any fall precautions were in place prior to this fall. V2 stated that the move-in nursing evaluation and fall risk evaluation are documented in the resident's electronic medical record. V2 stated that clinical evaluations are completed upon admission (move-in-nursing evaluation) and yearly. V2 stated that she is unable to find R1's move-in-nursing evaluation or a fall risk evaluation. V2 stated that V1 (Executive Director) or she is responsible for initiating and updating the residents' service plans. V2 stated that the negotiated risk form would be part of the resident's service plan. V2 stated that she was not aware a negotiated risk form needs to be completed per this facility's fall prevention policy. V2 stated that she does not know what R1 hit his head on but R1 was transported to the hospital and returned with five sutures to the left side of his forehead.

On 11/25/24 at 3:25PM, V7 (Caregiver) stated that she and another caregiver were transferring R1 in wheelchair in R1's room. V7 stated that she took off R1's shoes. V7 stated that R1

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wanted his shoes on so R1 reached down to get his shoes and fell forward out of wheelchair and hit head on dresser. V7 stated that the wheelchair was facing towards R1's bed, the other caregiver was standing next to wheelchair, and V7 was standing by the door not within arm's reach of R1. V7 stated that the other caregiver started to reach for R1 but R1 is a heavier resident. V7 stated that the caregivers were trained that they are not supposed to grab or help resident when falling so not to hurt themselves.

R1 was admitted to the facility on 7/19/2022. R1 has diagnoses including, but not limited to, dementia with anxiety.

R1's medical record, dated 9/15/24, V10 (LPN) noted R1 sent out for fall. R1 was in room with staff and leaned over to pick something up off floor. Per V11 (Caregiver) R1 fell and hit his head. Physician and family notified. V10 assessed R1. R1 presented with a cut to forehead and two skin tears to right arm, blood pressure 136/78, pulse 70 beats/minute, respirations 18/minute, temperature 96.7. R1 stated he was not in pain and did not want to go to hospital, V10 explained it was necessary to get his head checked by the emergency room physician. R1 stated "okay I'll go get checked".

R1's fall incident report notes R1 fell at 11:07PM on 9/15/24.

R1's fall final report, dated 9/20/24, does not note R1 required 5 sutures as a result of this fall.

There is no documentation found in R1's medical record noting a fall risk evaluation was completed at any time.

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R1's medical record notes a move-in-nursing evaluation was not initiated until 1/25/23 and not completed until 8/22/23.

R1's clinical evaluations, dated 5/8/23 and 12/4/23 note R1 requires assistance with dressing, toileting, ambulation, and transfers and uses a wheelchair.

R1's falls service plan, initiated 4/18/2023, notes interventions: encourage R1 to wear appropriate footwear, provide wheelchair and remind R1 to lock brakes, R1 is on hourly safety checks.

There is documentation found noting R1's falls service plan was updated after fall on 12/15/23 or on 9/15/24 until 11/25/24.

2. On 11/25/24 at 10:06AM, V2 (Administrative Services Coordinator) stated that R2 can get up and walk. V2 stated that R2 is not able to make her needs known. V2 stated that R2 can tell a story but not able to tell the exact story of what happened. V2 stated that the nurse is expected to document alert charting x 72 hours post fall. V2 stated that the nurse is expected to complete neurological checks x 72 hours for all unwitnessed falls. V2 stated that R2's fall incident occurred on 10/4/24 at 9:15PM. V2 stated that the move-in-nursing evaluations and clinical evaluations are to be completed by her. V2 stated that she did not know she was supposed to be completing these forms. V2 stated that she thought the nurse admitting the resident was responsible for completing this form. V2 stated that there is no documented fall risk evaluation completed for R2.

R2's fall initial report was not sent to the State Surveying Agency until 10/11/24. A final report

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was not submitted. There is no documentation in the report noting R2 required 6 sutures above right eyebrow after fall on 10/4/24.

There is no documentation noting a clinical evaluation or fall risk evaluation were completed at any time since admission to this facility on 10/19/23.

V2 presented a move-in-nursing evaluation for R2, dated 10/19/23, that is 9 pages in length without any documentation on it other than R2's name.

R2's medical record notes R2 has had fall incidents on 11/1/23, 11/12/23, 12/2/23, 12/31/23, 2/6/24, 2/10/24, and 10/6/24.

There is no documentation noting a falls service plan was initiated or updated after any of R2's falls.

R2's medical record, dated 10/4/24, notes R2 was found on the floor by caregiver while doing rounds. R2 stated that she was trying to get something from the table, lost balance, and fell. R2 sustained a laceration above right eyebrow. R2 was transported to the hospital and received six sutures above right eyebrow.

3. R4's medical record notes R4 was admitted to this facility on 3/5/2024.

On 11/25/24 at 10:06AM, V2 stated that R4 was transported to the hospital emergency room after his second fall on 9/20/24. V2 stated that R4 returned to this facility and fell on 9/21/24 at 7:47PM. V2 stated that R4 was sent to the hospital on 9/21/24 at 8:45PM. V2 stated that

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she is unable to find any fall incident reports for the two falls on 9/20/24. V2 stated that the nurse is expected to complete a fall incident report. V2 stated that neurological checks are completed for all unwitnessed falls. V2 stated that she believes all residents are to have a service plan initiated upon admission and then updated as needed. V2 is unable to find a service plan for R4. V2 stated that R4 did have a clinical evaluation completed in April.

V2 presented a move-in-nursing evaluation for R4, dated 4/18/24, that is 9 pages in length without any documentation on it other than R4's name.

On 11/25/24 at 12:55PM, V6 (LPN) stated that on 9/20/24 staff lowered R4 to the floor because he was feeling weak. V6 stated that she was notified by caregiver. V6 stated that V6 assessed R4 on the floor in hallway. V6 stated that R4's gait was unsteady. V6 stated that she did not complete an incident report or notify V2, the physician, or family because R4 did not fall.

On 11/25/24 at 3:20PM, V11 (Caregiver) stated that she was present during one of R4's falls. V11 stated that R4 was in bed asleep with pillows on side to prevent him from getting up. V11 stated that she heard R4 yelling for help. V11 stated that R4 was on the floor on his side trying to get up. V11 stated that she got the other caregiver to stay with R4 while she got the nurse. V11 stated that the nurse assessed R4 and then R4 was assisted into wheelchair. V11 stated that the nurse was attempting to reach V2, but she was not answering. V11 stated that the knot on R4's head continued to get bigger while they were waiting for V2 to call back. V11 stated that R4 fell asleep in wheelchair while waiting for the

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ambulance to transport him to the hospital.

R4's medical record, dated 9/20/24 at 1:00PM, V5 (LPN) noted she was informed R4 was on his bedroom floor. Alert. Assessed. Small right temporal hematoma and small abrasion right side of head. Blood pressure 126/74, pulse 86 beats/minute, respirations 18/minute, temperature 97.0. Neurological check within normal limits. R4 was assisted to chair. Nurse practitioner and family informed. R4 transported to the hospital for further evaluation.

There is no documentation that a falls incident report was completed after this fall.

R4's medical record, dated 9/21/24 at 4:45PM, V6 (LPN) noted R4 observed on the hallway floor. No apparent injuries noted. R4 assisted with lifting to his feet and became very combative. R4 was placed in a wheelchair because gait is unsteady. Unable to obtain blood pressure and pulse due to resistance.

There is no documentation that a falls incident report was completed after this fall.

R4's medical record notes R4 had fall incidents on 3/27/24, 3/30, 4/6, 6/12, 7/22, 9/20, and 9/21.

R4's medical record does not note a move-in-nursing evaluation, clinical evaluation, fall risk evaluation, or service plan were completed during R4's stay at this facility.

This facility's fall prevention policy, dated 06/2021, notes fall prevention guidelines guide staff through a structured process to screen and identify residents for predisposing risk factors or a history of falls. The staff implements

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S9999	Continued From page 8 precautionary measures to reduce the risk of falls by individualizing resident needs. Mobility and fall information are documented on the move-in on the move-in-nursing evaluation and the fall risk evaluation. In the event that a resident is at risk for falls, interventions are incorporated into the resident's service plan and a negotiated risk is initiated and signed by the resident, power of attorney, guardian, or family member. On-going follow-up of fall: staff to be notified of fall prevention plan, expected results, what to report, observations and how to document those observations. Review, modify, and evaluate the effectiveness of the interventions. Track falls to determine patterns. This facility's clinical evaluation policy, updated 11/2024, notes clinical evaluations are a critical component to identifying health and wellness care needs for residents. A clinical evaluation should be completed upon move-in, around 30 days, annually, and with any changes in condition. The clinical evaluation is initiated at the time of move-in and is completed within the first 24 hours. On move-in, a fall evaluation should be conducted. (B)	S9999		