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S 000	Initial Comments Investigation of Facility Reported Incident of November 22, 2024/IL182266	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)4)5) 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 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)

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.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,

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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.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review the facility failed to adequately supervise a resident with a history of falls and complete a thorough fall investigation for one of three residents (R3) reviewed for falls on the sample list of 14. Failing to supervise R3 resulted in R3 falling and suffering fractures.

Findings include:

R3's Current Diagnoses Sheet documents the following: "Unspecified Dementia, Severe with Other Behavior Disturbance, Generalized Anxiety, Primary Insomnia, Unsteady On Feet, and History of Falling."

R3's Minimum Data Set date 12/03/24 documents R3 has severe cognitive impairment.

R3's Care Plan History (hx) dated as revised 07/26/2024, documents the following:
"Falls: Resident does not understand mobility limits due to cognitive limitations. She has a hx (history) of falls with major to min (minor) injury. She is unsafe to use a wheelchair or walker d/t (due/to) severe cognition impairment. She

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tolerates ambulating holding the hand of a staff for directional purposes. Her impaired cognition and weakness put her at high risk for falls."

On 12/27/24 at 1:30 pm V5 (Certified Nursing Assistant/CNA) stated "I got here about 6:00 am (11/22/24). I was told in report that morning that (R3) had not slept all night. She (R3) was still up. I could tell she was really, tired. I took her to the dining room for breakfast. I laid her in the recliner, by the nurses' station first thing, after she (R3) ate (breakfast). She fell right to sleep. (R3) was sleeping, good. I was going to leave her in the recliner at lunch and feed her when she woke up on her own. (V1 Administrator) had said even if residents are sleeping, we have to bring them to the dining room to make sure they eat. We were told everybody needs to be up and in the dining room every meal. I got (R3) up and in her wheelchair. (R3) was really antsy and fidgeting in her chair. She was trying to stand up. I reminded her it was time to eat thinking that would help settle her a little bit. I took her to the dining room. I think I locked her wheelchair. She was still real tired when I got her up for lunch. (R3) was really anxious again and fidgeting in her chair. She was shaking the arms of her wheelchair the last time I saw her in there (dining room). There were other residents in the dining room then, but no staff. I had to go back down the hall to get the other resident up and out to eat. The other staff were also getting people up. I saw activity people bringing some residents to the dining room too. I think (V7 Activity Assistant) is one of their names. I left to get another resident. I was about halfway down the hall. The residents at (R3's) table are not alert and oriented. (R7) and (R8) are (alert and oriented). They were seated across from (R3) a couple tables away. (R7) is the one that screamed '(R3) fell.' I think it was (V6 CNA) and

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(V14 Licensed Practical Nurse) that got to (R3) first, and maybe (V7 Activities). (R3) was on the floor and bleeding. (V2 Registered Nurse) came and put a dressing on her (R3) head. I could see she (R3) was real hurt. I felt bad. I wish I would have stayed with her in the dining room when I saw her shaking the arms of her wheelchair. I could have talked to her and calmed her down. I was focused on getting everybody down my hall up for lunch."

(Witness R7's) Minimum Data Set dated 12/12/24 documents R7's Brief Interview of Mental Status score of 15 out of a possible 15, indicating no cognitive impairment.

On 12/27/24 at 2:07 pm R7 stated "I (R7) am the one (resident) that yelled that (R3) was on the floor. There were no staff in the dining room at the time. Staff would come in and out and did not seem to notice (R3) was agitated. I had been watching her as she became more restless over the course of time that we sat in the dining room. I can't tell you how long we were waiting for our meal. Some days it is 15 or 20 minutes and other times it can be closer to an hour. That day I can't specifically say. Even if it was only 15 minutes, (R3) was restless the whole time. She was in the dining room when I came in, so I can't be sure how long she had been there. I saw her stand up from her wheelchair, take one step, and went down immediately. I had to scream, very loud for somebody to come. An activity person (unidentified) and a nurse (unidentified) were in the dining room within probably 15 seconds. It all happened so quick. You could tell (R3) was in pain and bleeding. A bunch of other staff came in to help with her too. An ambulance was here within a few minutes. (R3) was sent to the hospital for treatment."

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On 12/31/24 at 3:30 pm V7 (Activity Assistant) stated "Yes, I responded to (R7's) yell that (R3) had fallen (fell). I was the first person into the dining room when (R3) fell. There wasn't any staff around. (R3) was laying on the floor face down, with her feet up against the wheelchair. Her feet were freely moving it (the wheelchair) because the wheelchair was not locked. It looked like she went over the side of the wheelchair. I moved the wheelchair, so her feet wouldn't get caught. I then went and got a nurse (unidentified). (R3) is a known fall risk. There is supposed to be staff in the dining room always watching the residents. There wasn't that day. Had there been somebody, maybe her fall could have been prevented. If her wheelchair was locked, she might have had a better chance of not falling too. No one asked me to make a statement, or they would have known these things."

R3's Final Investigation Report dated 12/02/24 to state surveying agency regarding R3's fall 11/22/24 was provided with witness statements. There is no documentation of V7 (Activity Assistant) being interviewed and no documentation of R3's wheelchair being unlocked. R3's same Final Fall Investigation Report dated 12/02/24 documents the following: "Root cause: IDT (Interdisciplinary Team) has determined the cause of the fall is due to (R3) is not aware of safety limitations due to cognition status and self-transferred due to incontinence. Intervention- Resident (R3) will be toileted prior to meals and frequently to ensure resident is dry. Staff with be in-serviced (educated) on leaving (R3) in the dining room unattended. PT/OT (Physical Therapy/Occupational Therapy) will eval (evaluate) and treat upon returning to the facility. (R3) had an ORF (open reduction-surgical

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procedure) to Right femur on 11/24/24. (R3) has a splint to her R (right) arm for a proximal humerus fracture."

On 12/31/24 at 11:55 am V2 (Registered Nurse/RN) stated she responded to R3's fall in the dining room, after hearing some kind of noise. She was third staff in the dining room at time. "(R3's) head was bleeding from a laceration on her head. I (V2) applied a pressure dressing and cleaned the area, while two CNAs (unidentified) were getting vital signs. The two CNA said the floor nurse (unidentified) was calling 911. The ambulance came and (R3) was transferred to the gurney for transport to the hospital." V2 also stated "I come in early in the morning to make sure the residents are all up and out for breakfast. That came from me (direction for all resident to be in the dining room for meals). We are addressing residents left in bed. The CNAs have been told all residents come to the dining room, unless there are issues that require them to remain in their beds. I was told after the fall, (R3) had not slept the night before. That would be a circumstance CNAs would relay to the nurse, so (R3) could continue to sleep. There is to be a CNA, always in the dining room, while the other staff are getting the other residents out for meals. We discussed, during morning meeting the next day (after R3's 11/22/24 fall), that there was no one in the dining room, supervising the residents. That should never have happened. Her (R3's) fall could have been prevented."

On 12/31/24 at 4:00 pm V14 (Licensed Practical Nurse/LPN) stated "I did not witness (R3's) fall. I came out of my office when I heard (R7) yell for help. (R3) was lying flat on her stomach, with the right side of her face on the floor. She was very tense and never talked. The wheelchair was

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already moved away from (R3's) feet, so I don't know if it was locked or not. I heard she (R3) was really groggy when they got her out of the recliner to bring her to the dining room that day. I think it was (V19 Social Service Director) that called 911."

R3's AIM (Assessment/Evaluation Intercommunication Management/Intervention) For Wellness- Event Record dated 11/22/2024 at 10:55 am documents the following: "Late Entry: Note Text: Event Details: (R3) appears to have experienced an alleged Intentional Change in Plane; Witnessed w (with)/head involvement. Event was first noted on 11/22/2024 10:55 am Evaluation of the resident and event occurred on or about 11/22/2024 11:00 AM. Just prior to/at the time of the event (R3) appears to have been sitting in w/c (wheelchair) at the dining room table. (R3's) account of the event is unable to explain what happened. Witness to the event includes: (R7) stated she (R3) stood up from her w/c and started to walk and immediately fell to the ground hitting her head. Location of the event is: Dining room. Description of the environment at the time of the event includes quiet. Staff's immediate response is noted as Assessed resident, VS (vital signs) taken, EMS (Emergency Medical Service) called. Unable to determine if this type of event is known to have occurred previously."

R3's Hospital "Emergency Documentation" signed by V29 (Emergency Room/ER Physician) dated 11/22/24 at 12:54 pm documents the following:
"Chief Complaint: Patient to the ED (Emergency Department) via EMS (Emergency Medical Service) from (Facility) for (an) unwitnessed fall. Patient (R3) was in dining room, stood from her

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wheelchair, and fell. Laceration to right forehead skin tear to right upper arm."
"History of Present Illness: This is a 93-year-old female brought to the emergency room by ambulance from (facility name) nursing home for a complaint of a fall with right hip pain. The patient herself is quite demented so I am unable to get any history from her. According to the chart the patient was in the dining room and stood up from her wheelchair and fell. I am unable to get any details from the patient due to her dementia, no other description of the fall was given.
Review of Systems: Review of systems is unobtainable other than what is stated in the HPI (history of present illness).
Physical Exam: Vital signs reviewed. In general, the patient is awake, pleasantly demented, appears in no acute distress. Pupils are equal, sclera clear, TMs (Tympanic Membrane's/eardrum) normal, nares are pink, oropharynx is clear. The patient's right upper forehead has a 2 cm (two centimeter) vertical superficial abrasion without any surrounding soft tissue swelling or hematoma. Neck has no midline tenderness or step deformities. Heart is regular rate and rhythm without murmurs. Lungs are clear. Abdomen is soft, nondistended, with active bowel sounds. Extremities shows shortening and external rotation to the right lower extremity. The patient has significant tenderness palpation of the right hip. There is no tenderness to the knee or ankle on that side. Her right upper extremity at the mid bicep triceps area shows a 1-1/2 cm superficial skin tear without any bruising or hematoma formation. The patient has marked tenderness to palpation of the proximal and mid right humerus and there is crepitance, shoulders, elbows, and wrists are nontender and have no deformity. Palpation of her chest wall and ribs shows no tenderness or deformity."

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The same report documents:
"ED Course: An x-ray was performed of the patient's right hip that I reviewed. The patient has a displaced intertrochanteric right hip fracture. I did order baseline labs. X-ray of the right humerus shows a comminuted and mildly angulated and displaced fracture to the proximal humerus below the humeral head. A CT (Computed Tomography) of the brain without contrast was performed and I reviewed the images myself. There is atrophy and periventricular lucencies but I do not see any evidence of bleed or midline shift. Still awaiting radiology report. I did contact (V30 Physician) from orthopedics, and he will consult. He feels that the humerus fracture will be nonoperative and the hip will be operative repair. I spoke with (V31 Nurse Practitioner) from the hospital service and the above was discussed with her. She does agree to admit the patient for her right humerus and right hip fractures with orthopedics consulting. I did have nursing staff placed the right upper extremity in a long-arm sugar-tong splint. Baseline labs were drawn."

The facility "Fall Prevention" policy dated 11/18/17 documents the following:
"Policy: To provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility."
The same policy documents direct all staff 'must observe residents for safety.' If residents with are observed up or getting up, help must be summoned, or assistance must be provided.

"A"