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S 000	Initial Comments Facility Reported Incident of September 13, 2024/IL00181457 300.610a) 300. 1210a) 300. 1210b) 300.1210d)6) 300.1220b)2)3)	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300. 1210a) 300. 1210b) 300.1210d)6) 300.1220b)2)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 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	S9999		

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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 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.
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.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

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2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
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 modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These Requirements were not met as evidenced by:

Based on the interview and record review, the facility failed to provide appropriate assistive devices and staff supervision while walking to two cognitively impaired, high-risk falls residents (R1, R2) out of 3 residents reviewed for incidents/accidents. These failures resulted in R1 bumping R1's nose on the hallway countertop and sustained a nasal fracture.

Findings Include:

R1's clinical records show an initial admission

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date of 11/30/22 with included diagnoses but not limited to Unspecified Dementia Without Behavioral Disturbance, Unspecified Psychosis, History of Falling, and Altered Mental Status. R1's Minimum Data Set (MDS) dated 9/09/24 shows R1 has severe cognitive impairment and requires supervision or touching assistance with walking. R1's fall risk evaluation dated 9/09/24 shows R1 is at high risk for falls. This fall risk evaluation also shows R1 has unsteady gait, has memory problem, and is able to walk with assistance and/or assistive device. R1's restorative mobility evaluation dated 9/09/24 shows R1 uses a walker.

R1's fall care plan initiated on 12/06/22 shows R1 is at risk for falls related to impaired balance, weakness, and activity intolerance. This care plan also shows that R1 is ambulatory and uses a rolling walker with cueing assistance. One of the fall interventions in the fall care plan reads in part, "I have periods of forgetfulness. I would like staff to frequently reorient me to my surroundings" (date initiated 12/06/22). R1's Activity of Daily Living (ADL) care plan date initiated on 11/30/22 shows R1 requires cueing to partial assistance with ADLs (transfers, walking), and R1 primarily utilizes a walker but oftentimes is forgetful to use a walker for ambulation; therefore, R1 is at risk for falls/injury. One of the interventions reads in part, "Provide [R1] with reminders to use [R1's] walker, cue/assist if necessary" (date initiated 9/09/24).

The facility's final incident report sent to the state agency on 9/20/24 at 7:00 PM documents in part: On 9/13/24, at about 7:10 PM, [R1] was ambulating in the hall while holding hands with another female resident [R2]. The other resident began to fall, and as [R1] was still holding onto

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[R2's] hand, [R1] was pulled forward and bumped [R1's] nose on the hallway railing. [R1] did not fall or have a change in plane, [R1] was noted with swelling and skin tear measuring 0.2x0.5cm [centimeters] to the nose. Minimal bleeding noted. Abrasion was cleansed and covered with a band aid. Pain medication administered and ice pack applied. Neurochecks initiated. [V16 Advanced Practice Nurse] was notified with order to send to ED [Emergency Department] for evaluation. This report also documents that R1 was transferred to the acute hospital via emergency [911] where R1 was diagnosed with closed fracture of nasal bone and returned to the facility on 9/14/24 at 1:20 AM. R1's progress notes documented by V12 (Licensed Practical Nurse) indicates that per ER [Emergency Room] department, R1 has a bilateral nasal bone fracture and will return to the facility.

R1's hospital discharge instructions printed on 9/13/24 at 10:58 PM documents that R1's was seen for a fall and [R1] hit [R1's] nose with a diagnosis of "Closed fracture of nasal bone, initial encounter."

R2's clinical records show an initial admission date of 4/29/22 with included diagnoses but not limited to Unsteadiness on Feet, Adult Failure to Thrive, Other Abnormalities of Gait and Mobility Unspecified Dementia Without Behavioral Disturbance, and History of Falling. R2's MDS dated 8/21/24 shows R2 has severe cognitive impairment and requires supervision or touching assistance with walking. R2's fall risk evaluation dated 8/16/24 shows R2 is high risk for fall. This fall risk evaluation also shows R2 has unsteady gait, has memory problem, is able to walk with assistance and/or assistive device, and just had a fall.

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R2's fall care plan initiated on 6/11/22 documents in part: R2 is at high risk for falls related to a history of falls, behaviors, current medication use, poor safety awareness, unsteady gait, and disease process. R2 ambulates with use of walker with cueing and redirection from staff due to wandering behaviors. One of the fall interventions in the fall care plan reads in part, "Assist [R2] with walking, remind [R2] of safety precautions as needed. May require frequent reminders and cuing of assistance requires for ambulation" (date initiated 6/21/22). Another fall care plan intervention reads in part: "Use of assistive device during ambulation to prevent falls" (date initiated 6/11/22). R1's behavior care plan initiated on 6/16/22 documents in part: R2 exhibits poor safety awareness and will walk without R2's walker or regard to R2's own safety which increases R2's risk for falling and/or obtain an injury. One of the interventions reads in part, "Provide frequent cues and redirection to wait for staff assistance" (date initiated 6/16/22).

The facility's change in condition form for R2 dated 9/13/24 at 7:10 PM documents in part: R2 holding hands with another resident coming out of the room. The other resident tripped over [R2], and R2 sat down on the floor. Head to toe assessment done, no skin alteration noted, no injury. Vitals taken all within normal limits, denies pain. [R2] alert and oriented x 1, range of motion within the baseline.

On 1/12/25 at 10:50 AM and 1:03 PM, interviewed V10 (Agency Registered Nurse) and stated that V10 is the nurse in charge for R1 and R2. V10 stated that R1 needs one person assistance when walking with the use of a rolling walker. V10 stated R1 is confused. V10 stated

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that R2 is also ambulatory using a rolling walker. V10 stated R2 needs one staff assistance with walking because R2 gets confused and forgetful and is high fall risk.

On 1/12/25 at 11:02 AM, interviewed V2 (Director of Nursing) and stated that V2 witnessed the incident that happened with R1 and R2 on 9/13/24 at around 7:10 PM. V2 stated, "I went to the floor to do rounds. When I came out the elevator, I turned left to go down the hall and saw [R1] and [R2] walking together. There were no staff walking with them. [R1 and R2] were not using their walkers. [R1] was holding [R2] and walking together. Back there on the third-floor unit there is a cove. There is a countertop on the hallway like an island. I saw [R2] began to fall and [R1] was holding on to [R2] they were walking face to face holding each other's both hands. [R2] was walking backwards and then [R2] lost [R2's] balance and fell backwards. [R2] kind of slid down the wall. [R2's] back was leaning on the wall. [R1] was still holding [R2's] hands and went forward hitting [R1's] face on the countertop. [R1] had a nasal bone fracture. [R1] went to [Acute] hospital." V2 stated that fall assessment is completed upon admission, post fall, quarterly, and re-admission. V2 stated that the fall assessment's purpose is to assess the resident they are high fall risk. V2 stated that the care plan would address fall interventions to prevent from residents' from falling. V2 stated fall interventions include the resident's needs, based on the fall assessment, and is updated based on the root cause analysis post fall. V2 stated that R1 ambulates by herself with a walker and is quite independent. V2 stated that R2 has a walker needs assistance with walking. V2 stated that R2 is very forgetful and needs multiple re-direction. V2 stated that R2 needs staff assistance with

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walking, toileting, and transfer. A follow up interview conducted with V2 on 1/12/25 at 3:47 PM and stated that there were no other staff witnesses for R1 and R2's incident.

On 1/12/25 at 1:10 PM, a phone interview conducted with V12 (Licensed Practical Nurse) and stated that R1 has dementia, walks with a walker, and wanders around. V12 stated that when R1 she walks somebody has to be with [R1]. V17 stated, "We have to keep an eye on [R1] and supervise [R1]. [R1] is high risk for fall. [R1] forgetful. [R1] uses a rolling walker, and [R1] needs to use that all the time. [R2] also walks with walker and is more disoriented than R1. [R2] only speaks Spanish a little bit English. [R2] needs supervision at all times when walking. [R2] is a high fall risk. [R2] also needs rolling walker at all times." Surveyor asked V12 regarding the incident that happened on 9/13/24 with R1 and R2. V12 stated, "I can't recall the exact time. I was passing medication at that time. It was evening meds. I can't recall the exact time. [V2] brought to my attention that [V2] witnessed [R1] and [R2] were walking holding hands. They were not using the walkers. [R1] lost balance and bumped [R1's] nose on the countertop by the front of [R1's] room. I did a full assessment for both. I took care of [R1]. [R1] was not complaining of pain after the incident but [R1] was holding [R1's] nose. We saw discoloration on [R1's] nose, no bleeding, just a superficial cut on the bridge of [R1's] nose. At that time [R1] did not complain of pain. [R1's] vitals were stable. We called 911 and the doctor." V12 stated that R1 came back to the facility the same night with nasal fracture as R1's diagnosis. On 1/12/25 at 4:38 PM, a follow-up phone interview was conducted with V12. V12 stated that V12 cannot recall what time the last time [V12] saw R1 and

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R2 before the incident. V12 stated that [V12] can only remember that R1 was in the dining room and R2 was in R2's room the last time V12 saw R1 and R2.

On 1/12/25 at 1:33 PM, interviewed V13 (Restorative Licensed Practical Nurse) and stated that the Section GG of the MDS shows the resident's functional assessment, including their mobility assessment. V12 stated that if the resident 's MDS is coded supervision or touching assistance for example if a resident is walking with a walker, the staff should be cuing, reminding, or guiding the resident during walking activity.

On 1/12/25 at 3:37 PM, I attempted to conduct a phone interview with V14 (Former Certified Nursing Assistant/CNA). Surveyor asked about the incident with R1 and R2 on 9/13/24. V14 stated that V14 is very sick and can't talk. V14 refused to be interviewed.

On 1/13/25 at 10:24 AM, a phone Interview conducted with V18 (Nurse Practitioner) and stated that V18 knows about the incident that happened on 9/13/24 between R1 and R2. V18 stated that R1 sustained the nasal fracture from the incident and was sent to the hospital. V18 stated that based on R1 and R2's cognitive and mobility statuses, R1 and R2 need staff supervision when walking and needs frequent monitoring. Surveyor asked V18 that if staff supervised and monitored R1 and R2 with walking would the incident had been prevented. V18 stated, "I'm sure the incident would not happen."

On 1/13/25 at 10:33 AM, a phone interview conducted with V2 and stated that for confused

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residents who are high risk for falls, fall interventions that the staff should be doing are frequent monitoring, re-direction, and to make sure residents are engage with activities. V2 stated that frequent rounding means the staff (Nurses and CNAs) are checking on residents every half hour.

The facility's "Fall Occurrence" policy dated 7/26/24 documents in part: It is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place, and reevaluated and revised as necessary. Those identified as high risk for falls will be provided fall interventions.

The facility's "General Care" policy dated 7/30/24 documents in part: It is the facility's policy to provide care for every resident to meet their needs. Upon admission or readmission, the facility will evaluate the resident for physical and psychosocial needs. Physical needs would include, but are not limited to ADL, wound care, medical needs, etc. Psychosocial needs would include but are not limited to areas of mental and psychosocial well-being. The facility will assist the resident to meet these needs, unless it shows that the resident's needs cannot be met in the facility. (B)