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	IL6002364	A. BUILDING: _____ B. WING _____	C 03/02/2025

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S 000	Initial Comments Complaint Investigation 2561516/IL187007	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210c) 300.1210d)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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S9999	Continued From page 1 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. 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 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 to ensure the safety of	S9999		

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one (R1) resident by not implementing resident centered fall interventions and failed to thoroughly investigate one (R1) resident fall with injury out of four residents reviewed for falls in a sample list of four residents. R1 experienced pain and bleeding after her fall thus was transported to and evaluated at the emergency room, where she received three sutures to her forehead because of the fall.

Findings include:

R1's Electronic Medical Record (EMR) documents medical diagnoses of Intracapsular Fracture of Left Femur, Left Artificial Hip Joint, Forehead Laceration, Protein Calorie Malnutrition, Diabetes Mellitus Type II, Morbid Obesity, Cerebral Infarction, Trans Ischemic Attack (TIA), History of Falling, Abnormalities of Gait and Mobility and Dementia.

R1's Minimum Data Set (MDS) dated 1/7/2025 documents R1 as severely cognitively impaired. This same MDS documents R1 requires supervision with toileting, bathing, dressing, personal hygiene, bed mobility and transfers.

R1's Fall Risk Assessment dated 12/21/24 documents R1 as a fall risk.

R1's Care plan intervention dated 10/10/2024 documents R1 is to wear non-skid socks while in bed. This same care plan documents an intervention dated 5/16/24 which instructs staff to ensure R1's Activities of Daily Living (ADL) are met and to provide a safe and secure environment.

R1's Change of Condition Evaluation dated 1/18/25 documents R1's bed was in low position

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prior to her fall.

R1's SBAR dated 1/19/25 documents R1 had an injury to her forehead with sutures in place.

R1's Nurse Progress Note dated:

-1/18/25 at 1:20 AM documents, "Observed (R1) in a pool of blood in a sitting position on the floor facing the door with her Left foot under her bottom. Evidence suggest (R1) may have hit her head on the nightstand. Cleaned blood off wound bed with Normal Saline and sterile gauze. Applied cold compress. Called 911 due to the amount of blood (R1) had lost."

- 1/18/25 at 10:42 AM documents, "(R1) came back to the facility from hospital at approximately 8:55 AM. (R1) has a stitch to forehead laceration, area has dried blood. (R1) has no complaints of pain to other parts of the body."

-1/18/25 at 10:49 PM documents, "Hematoma on (R1's) forehead with a one inch laceration. Pain scale 10 out of 10. Sutures intact."

-1/19/25 at 12:03 AM documents R1's emergency room nurse reported to the facility that R1 has three stitches and needs them removed in 5-7 days and needs to be seen by Physician in the next seven days.

-1/20/25 at 1:22 PM documents the facility interdisciplinary team reviewed R1's fall from 1/18/25. This same note documents, "Staff observed (R1) seated on floor of room by bed, facing door. Right leg extended; Left leg bent with Left foot under buttocks. Blood noted on floor. Laceration noted to (R1's) forehead. Bleeding controlled with clean dry dressing. No other

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injuries noted. Pain reported at laceration, no other complaints of pain/discomfort. (R1) reported that she "rolled out of bed" which is likely as prior to fall event resident was noted to be in bed. (R1) transported to emergency room. (R1) returned with three staples to forehead. Root Cause Analysis: (R1) rolled while sleeping and fell off the bed. IDT intervention: (R1's) bed to be in low position while she is in bed."

R1's Hospital Record dated 1/18/25 documents R1's chief complaint as Laceration, Head Injury and Fall. This same report documents R1 had a fall from her bed resulting in a forehead laceration.

R1's Final Report to the State Agency dated 1/22/25 documents R1 fell from her bed on 1/18/25 at 1:20 AM resulting in a 1.5 centimeter (cm) laceration that required treatment in the emergency room where three sutures were placed. This same report documents R1's care plan was updated with a new intervention of ensuring R1's bed is to be in low position.

On 3/1/25 at 9:30 AM, 1:15 PM and 3:20 PM R1 was lying in her bed. R1's bed was positioned up against the wall with the window approximately four feet from the ground. R1 had five pillows surrounding her head and torso on the wall side of her (her Left side). R1 was positioned on the right side of the bed closest to the room door. R1 did not have call light in reach. R1 was not wearing no skid socks.

On 3/2/25 at 10:00 AM R1 was lying in her bed with her call light laying over her bedside dresser, not within R1's reach or visual field.

On 3/1/25 at 9:40 AM V4 Agency Licensed

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Practical Nurse (LPN) stated V4 is R1's nurse. V4 Agency LPN stated she is unaware of how to find a resident care plan or how to find a residents fall interventions. V4 LPN stated she does not have any residents on her hallway that are considered being at risk for falls. V4 Agency LPN stated, "I just walk down the hall and if a resident has a floor mat in front of their bed, then I know that resident might have fallen before. If they (facility) don't put the mat down, that resident is not considered a fall risk."

On 3/1/25 at 9:55 AM V8 Certified Nurse Aide (CNA) stated she is R1's CNA. V8 CNA stated R1 is not considered a fall risk. V8 CNA stated the facility has a binder that tells you all the basic information including fall risk and interventions.

On 3/2/25 at 9:20 AM V21 Assistant Director of Nursing (ADON)/Registered Nurse (RN) stated he is the manager of the North building where R1 resided when she fell on 1/18/25. V21 ADON/RN stated R1 has fallen out of bed prior to 1/18/25. V21 ADON stated R1's sleeping patterns should have been included on her care plan. V21 ADON stated, "All of those pillows would have crowded (R1) out of her bed. It forced (R1) to sleep close to the edge of bed which wasn't safe. The staff should have answered (R1's) call light as soon as it was activated and not waited until they (staff) got to (R1) during rounds. (R1) has Dementia. (R1) didn't know what she was doing. That is why we (staff) are here is to help these residents. We (staff) all knew how she slept. I don't know why it wasn't on (R1's) care plan but it should have been. Then the agency staff would know to not put so many pillows in her bed."

On 3/2/25 at 3:30 PM V17 Certified Nurse Aide (CNA) stated she was the CNA on duty on

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S9999	Continued From page 6 1/18/25 when R1 fell obtaining a forehead laceration. V17 CNA stated R1 was known to be a 'wild sleeper' who tosses and turns all night. V17 CNA stated R1 is incontinent but also was able to use the bathroom. V17 CNA stated when she started her shift, she checks on all her residents and saw R1 lying in bed with her bed positioned up against the wall with the window. V17 stated R1 had five large pillows surrounding her head and torso on the wall side of her (her Left side). V17 stated R1 was positioned on the Right side of the bed closest to the room door. V17 CNA stated she was doing her rounds and heard R1 screaming. V17 CNA stated when she went to check on R1, R1 was laying on her stomach on the floor in between the bedside dresser and bed with her head facing the door. V17 CNA stated R1 was looking at me when I walked into her room with a very scared, panicked look on her face. V17 stated she could tell that R1 was scared. V17 CNA stated there was no one around, so she had to leave R1 to get V18 Agency Licensed Practical Nurse (LPN). V17 stated when they (V17, V18) both returned to R1's room, she was sitting on the floor with her back leaning against her bed. V17 stated R1 was wearing one sock, and the other foot was bare. V17 CNA stated R1's bed was already in low position. V17 CNA stated the staff on the previous shift had placed R1's five pillows on her bed. V17 CNA stated she was aware of R1's position in bed and decided to wait until time for rounds to reposition R1. V17 stated, "I should have taken those pillows out. I knew better. But really, that should have been on (R1's) care plan so the agency staff will know better. We (staff) that work here all know that. It is the agency staff that put them there. I just should have taken them out as soon as I saw them. That was an awful night for (R1) and all of us (staff)."	S9999		

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On 3/2/25 at 3:50 PM V18 Agency Licensed Practical Nurse (LPN) stated R1 was a 'wild sleeper'. V18 LPN stated she was notified by V17 CNA that R1 had fallen. V18 LPN stated when V18 arrived at R1's room, R1 was sitting on the floor with her right leg extended and her left leg bent as R1 was sitting her Left foot. V18 LPN stated R1's sheets were still on her bed, but her facility blanket, and her personal comforter were blood soaked and twisted up in her legs. V18 LPN stated R1 had a large pool of blood on the floor next to her and her head was bleeding profusely. V18 LPN stated she provided first aid and called emergency services. V18 LPN stated R1 was complaining of pain to her forehead. V18 LPN stated R1 had one sock on, and the other foot was bare. V18 LPN stated she believes R1 was trying to get up to use the bathroom when she got tangled in the blankets and fell. V18 LPN stated R1's call light had been activated. V18 LPN stated R1 would not have had a safe position in her bed due to all the pillows. V18 LPN stated, "I work agency, so I really do not know these residents that well. I rely on the facility staff. I have worked with (R1) before and know she should not have had all those pillows and also the staff should have answered her call light so she wouldn't have tried to get up on her own."

On 3/2/25 at 2:40 PM V16 Nurse Practitioner (NP) stated R1's fall on 1/18/25 resulted in a trip to the emergency room for assessment and treatment of her forehead laceration which required three sutures. V16 NP stated R1's fall could have been prevented if the fall interventions were in place. V16 NP stated the staff should know where to find fall interventions for all residents, know who is at risk for falls and be able

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S9999	Continued From page 8 to follow the fall care plan interventions to prevent falls with major injury like R1's 1/18/25 fall. V16 NP stated R1 could have sustained neurological deficits from her head injury she sustained at the facility. V16 stated residents who are assessed to be a fall risk should have care plan interventions initiated and in place that are consistent with each residents patterns, behaviors and capabilities. V16 NP stated the staff should assess every resident at risk for falls to create individual care plans that are centered around the individual's needs. V16 NP stated R1's fall could have been prevented if the facility would have created an accurate care plan and followed fall interventions that were specific to R1. The facility policy titled Falls Clinical Protocol revised March 2018 documents the staff and Physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable. (B)	S9999		