| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | IL6002133 | A. BUILDING: _____ B. WING _____ | C 02/25/2025 |

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| S 000 | Initial Comments<br><br>Facility Reported Incident of 01/20/25/IL186164 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210b)<br>300.1210d)6)<br><br>300.610a)<br>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.<br><br>300.1210 General Requirments for Nursing and Personal Care<br>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.<br><br>d) Pursuant to subsection (a), general nursing | S9999 | | |

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|---|---|---|---|---|
| S9999 | Continued From page 1 | S9999 | | |

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.

These regulations were not met as evidenced by:
Based on interview and record review the facility failed to position residents properly to prevent injury for 1 of 3 residents (R1) reviewed for accidents in a sample of 11. This injury resulted in R1 sustaining a closed displaced fracture of right femoral neck.

This past non-compliance occurred between 01/19/25 and 01/23/25.

Findings include:

R1's face sheet documents an admission date of 06/06/24 with diagnoses including: fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing, Alzheimer's disease, osteoarthritis, iron deficiency, shortness of breath, nutritional deficiency, anxiety disorder, insomnia, muscle weakness, rheumatoid arthritis, pain, unsteadiness on feet, age related osteoporosis without current pathological fracture, mid cognitive impairment of uncertain or unknown etiology, vitamin D deficiency, displaced intertrochanteric fracture of left femur, presence of right artificial hip joint, nausea with vomiting, major depressive disorder.

R1's Minimum Data Set (MDS) dated 01/29/25

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|---|---|---|---|---|
| S9999 | Continued From page 2 | S9999 | | |

documents a Brief Interview for Mental Status (BIMS) score of 02, indicating R1 has severe cognitive impairment. R1 is documented as being dependent for being able to wheel 50 feet with two turns in a manual wheelchair and dependent for being able to wheel 150 feet in a manual wheelchair.

R1's care plan documents a problem of pain with a start date of 07/30/24 with an approach of: handle gently and try to eliminate any environmental stimuli with a start date of 07/30/24. R1's care plan documents a problem category of: ADLs (Activities of Daily Living) functional status/rehabilitation potential with a problem start date of 06/06/24 with an approach listed as: overall I (R1) require extensive assistance with oral care, extensive with bathing, extensive with grooming, limited with eating, extensive with dressing, extensive with mobility with a start date of 06/11/24 and an approach listed as: safety: I (R1) will need to be monitored to prevent falling in my new environment. I will need assistance with bed/chair mobility, assistance with transfers, assistance with locomotion to prevent falling or injury with a start date of 06/11/24.

R1's "Serious Injury Incident Report" to the Illinois Department of Public Health (IDPH) dated 01/27/25 and is documented as a final report. This report documents an incident date of 1/20/25 and documents under the section titled, "detailed incident summary" that "facility ordered an x-ray on 01-20-25 due to resident grimacing in pain and having issues standing and rolling in bed. X-ray showed an acute subcapital right femoral neck fracture. DON (Director of Nursing) notified, family POA (Power of Attorney) of x-ray results and they wanted her sent to the hospital.

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|---|---|---|---|---|
| S9999 | Continued From page 3 | S9999 | | |

Resident (R1) has an extensive history of Alzheimer's disease, osteoarthritis, nutritional deficiency, muscle weakness, rheumatoid arthritis, age related osteoporosis, mild cognitive impairment, vitamin D deficiency, past MVA (motor vehicle accident) where her right side was crushed and had screws in femoral plate. Resident was sent to the hospital and admitted. Resident's last fall was 01/07/25 with no complaints or pain noted. Following facility investigation while facility attempted to weigh resident her position in the wheelchair resulting in residents leg making contact with the bar on the scale resulting in impact to the right leg/foot area. Upon immediate assessment of resident she denied any pain or discomfort, following assessment noted grimacing from resident resulting in facility initiated x-ray. Due to resident's age, medical history, ortho notes of previous ORIF (Open Reduction Internal Fixation) of hip along with the accident all being contributing factors resulting in fracture. Facility has began reeducation and training on nurse on body alignment and positioning and have scheduled additional training. Facility will continue to monitor for any additional changes and needs and address any concerns."

The facility investigation documents were requested from the facility and provided for review. These documents included "Incident Investigation Reports" documenting interviews with V5 (Licensed Practical Nurse/LPN) and V6 (Certified Nursing Assistant/CNA) and document the following:
V5's statement dated 01/21/25 documents "on Sunday 01/20/25 (per calendar Sunday's date was 1/19/25) I got reweight [sic] on the scale when pushing her on the scale she had her legs crossed and right foot hit the bar. Resident (R1)

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|---|---|---|---|---|
| S9999 | Continued From page 4 | S9999 | | |

said 'ouch' wheelchair backed up and repositioned. Upon assessment ankle and foot evaluated and no abnormalities noted."
V6's statement dated 01/21/25 documents "over the weekend I noticed the resident (R1) was a lot weaker than normal. She was a 2 assist (hard). Resident had complained of hip on Sunday for sure and foot when you put on her shoe (right foot but kept left foot straight). I had layed [sic] resident down Sunday evening, but had to get her back up to get weighed. The nurse V5 (LPN) helped me get her back in bed and I had mentioned it to her again of her hip pain and she noticed that her right leg went inward.

R1's Progress Notes document the following:
01/19/25 at 4:59 PM (recorded as late entry on 01/25/2025 at 4:59 PM) "This LPN (V5) needed to reweight [sic] res (resident) (R1) as a result from a previous weight not being consistent with baseline. Staff was assisting res into bed as nurse came in and explained the need to reweight [sic]. Staff and nurse assisted res back into wheelchair and this nurse pushed res to weight scale. Once weight scale was turned on res was gently pushed up the incline when nurse heard res say "ouch" nurse observed res right foot resting against the bar on weight scale. This nurse observed res right foot resting against the bar on weight scale. This nurse immediately retracted the WC (wheelchair) from weight scale. Skin was observed to be free of marks or abnormalities. No outward rotation or shortening noted to right lower extremity. No pain noted as evidence by no facial grimace or verbal complaints of pain upon assessment once res in bed.
01/20/2025 at 6:32 AM documents "(x-ray company) called and confirmed the order and will send to tech at this time."

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| S9999 | Continued From page 5<br><br>01/20/2025 at 3:14 PM documents "received notification via (x-ray company) that results show right hip is displaced. POA notified and stated would like resident sent to ER (Emergency Room) for evaluation. (V11-family) also stated that she understood that resident is a 'stinker' at times and tries to transfer self and does not communicate needs at times. Doctor notified and stated resident's osteoporosis and advanced age plays a factor in risk for fracture. PRN (as needed) Tylenol order increased, and preparations started to send resident to ER.<br>01/20/2025 at 3:16 PM documents "(R1) is displaying sign of pain such as grimacing and withdraw. This LPN adm (administered) tyn (Tylenol) and ineffective. NP (Nurse Practitioner) made aware and tramadol recommended for pain, tramadol administered.<br>01/20/2025 at 3:41 PM documents "(R1) left facility via EMS (Emergency Medical Services)"<br>01/21/2025 at 7:36 AM documents "(R1) admitted to hospital on 01/20/25."<br>01/25/2025 at 2:16 PM documents in part "(R1) arrived to facility via transportation from hospital. Report was being called in while resident was arriving. Report states that (R1) was admitted on the 20th for right hip fx (fracture) ...Script for Norco was sent in packet. Also states that can re-start tramadol. New order for ASA (aspirin) 325mg (milligrams) BID (twice a day) x 14 days. Trouble taking fish oil and was not able to take and states that they have been crushing meds in ice cream and no issues noted since crushing. States that resident will need a f/u (follow up) appointment with (name of physician) in 10-14 days post-surgery and surgery."<br><br>R1's X-Ray report with a date of service of 1/20/25 documents an 'Impression" of "Acute subcapital right femoral neck fracture." | S9999 | | |

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|---|---|---|---|---|
| S9999 | Continued From page 6 | S9999 | | |

R1's local hospital "History and Physical" dated 1/20/25 document a "Chief Complaint" of "hip pain." R1's "Discharge Summary" from the local hospital dated 1/25/25 documents a "Principle Problem" of "Closed displaced fracture of right femoral neck."

On 02/21/25 at 10:16 AM, V5 (Licensed Practical Nurse) stated, R1 was weighed earlier in the morning on 1/19/25 and her weight was off so she was supposed to get a re-weight for R1. They had already put R1 to bed so they had to get her back up. R1 was in her wheelchair and had her legs crossed. When she pushed her up on the wheelchair platform her right leg/foot hit the vertical bar of the scale on R1's left side. R1 said "ouch" and she backed up and repositioned the wheelchair on the scale. R1 did not have foot pedals on her wheelchair. V5 stated she weighed R1 around 5:30 PM. V5 said she assessed R1 when they put her to bed and did not notice anything and then she left at 6:00 PM. V5 stated, R1 is a small lady, she did not propel herself in her wheelchair and she did not move around a lot or flail around. V5 stated R1 is confused, R1 will babble and her sentences usually do not make sense.

On 02/20/25 at 1:36 PM, V7 (Certified Nurse Aide) stated, she worked at 6:00 AM on the Monday morning of 01/20/25. V7 stated R1 is not cognitive all the time but when she was transferring R1 she was saying "ouch" but she couldn't figure out where the pain was coming from. Then she saw R1's hip and it did not look right so she told the nurse and the nurse came down to evaluate R1. V7 stated she did not get R1 out of bed, the previous shift gets her up due to she gets up around 4:00 AM and moves to the

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|---|---|---|---|---|
| S9999 | Continued From page 7 | S9999 | | |

recliner before breakfast, she was getting R1 ready for breakfast.

On 02/20/25 at 1:50 PM, V4 (Licensed Practical Nurse/LPN) stated, V12 (CNA) came in at 10:00 PM on 1/19/25 and R1 was sleeping, they noticed on 1/20/25 at 4:00 AM when R1 gets up that she was uncomfortable and she starting assessing R1 then.

On 02/20/25 at 8:52 PM, V6 (CNA) stated she assisted R1 the weekend of 01/19/25. On 01/18/25 R1 seemed weak so another girl helped her transfer her. On 01/19/25, V6 noticed R1 had not been reweighed yet and reweighed her. Over the weekend R1 seemed like she was in pain but not excruciating pain. V6 said that she did not notice her foot on 01/18/25 or 01/19/25 until the evening of 01/19 when her foot seemed like it was turned inward. V6 said she told V5 about it.

On 02/20/25 at 12:05 PM, V8 (Therapy Director) stated she heard about the incident with R1 and her leg hitting the scale but she was not present. The injury R1 has can occur due to a fall, any impact with limb, depending on the person. R1 has declined after surgery, mainly due to her cognition level. R1 was evaluated for therapy but was declined due to cognition limitations.

On 02/21/25 at 5:35 PM, V1 (Administrator) stated the injury with R1 they felt was a positioning concern therefore all the staff has been in-serviced on correct positioning and transferring after the injury with R1 occurred.

The facility policy dated 09/08/23 titled, "Safe Patient Handling Program" documents: purpose: to identify, assess and develop strategies to control the risk of injury to resident, nurses and

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|---|---|---|---|---|
| S9999 | Continued From page 8 | S9999 | | |

other health care workers associated with lifting, transferring, repositioning, or movement of a resident. This program applies to all staff-assisted resident lifts, transfers and ambulation performed by employees under normal conditions, during the performance of non-routine tasks and in the event of emergencies.

Prior to the survey date, the facility took the following actions to correct the deficient practice:

1. A Quality Assurance and Performance Improvement meeting was held on 01/23/25. In attendance - V1, V4 (LPN), V13 (Director of Nursing/facility nurse practitioner), V15 (Registered Nurse), V16 (Medical Records), and V17 (Director of Maintenance).

2. Process/Steps to identify others having the potential to be impacted by the same deficient practice: All residents have the potential to be affected.

3. Measures put into place/systematic changes to ensure the deficient practice does not recur: V1, V4, V13 (Director of Nursing/facility nurse practitioner) and V14 (Regional Clinical Director) provided in-service to nursing staff regarding weight management policy and body alignments in chair and positioning. Completed on 1/23/25.

4. Plan to monitor performance to ensure solutions are sustained: V13/designee will audit transfer and repositioning 3 a week for 2 weeks, 2 times a week for 2 weeks and weekly for 1 month identifying transfer and repositioning.

(A)