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RICHLAND NURSING & REHAB	900 EAST SCOTT STREET OLNEY, IL 62450

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S 000	Initial Comments Facility Reported Incident of 1/27/25/IL187230	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)5) 300.1210c) 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	S9999		

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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. Restorative measures shall include, at a minimum, the following procedures:

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.

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

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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 safely transfer residents according to Transfer Assessments and Care Plans for three residents (R2, R3, R4) of four residents reviewed for falls in the sample of six. This failure resulted in R2, on 1/27/25, falling during a transfer and fracturing his 8th left rib and dislocating his left shoulder.

Findings include:

1. R2's Face Sheet documented an Admission Date of 2/18/20 and listed Diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-dominant side, Dissociative Disorder, Intermittent Explosive Disorder, and Unspecified Dementia, Mild, With Other Behavior Disturbance. R2 Minimum Data Set (MDS) dated 1/3/25 documented that R2 has severe deficits in cognition and requires substantial or maximal assistance for transfers.

R2's Fall Risk Assessment dated 12/28/24 indicated R2 is at high risk for falls. R2's Transfer Assessment dated 12/28/24 indicated R2 requires the assistance of 2 staff and a gait belt for transfers. R2's Care Plan dated 3/6/25 documented a problem area, "Resident at risk for falling related to weakness and history of putting self on floor from wheelchair. Resident will become upset and will act out by causing self to fall to the floor," with corresponding interventions, "Educate staff to make sure brakes (on

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wheelchair) are locked during transfers," and, "Reeducate/Inservice staff to not leave resident unattended while on toilet." The same Care Plan documented a problem area, "Resident has a history of episodes of yelling and screaming, refusing and resisting care, agitation and angry outbursts. Observed putting self on the floor out of the wheelchair, and attempting to come in close contact with other residents with his wheelchair. After having angry outbursts, resident will cause himself to fall out of his wheelchair," with a corresponding intervention, "Return at later time when resisting care/treatment."

R2's Incident Report sent to the Department submitted by V2 (Director of Nurses/DON) documents , On 1/27/25 R2 was transferring with assist to wheelchair from toliet and sat on the floor. The report also documents on 1/29/25 x-ray results revealed R2 has a fractured rib and dislocated shoulder.

R2's 1/27/25 Fall Investigation documented, "(R2) has come to the desk with request for CNA (Certified Nursing Assistant)/toilet, advised CNA will be available when current resident care completed. (R2) demonstrates anger stating,"I've been waiting for 45 minutes," advised (R2) that he had just left the dining area a few minutes ago, (now) anger has escalated and spun wheelchair around, hitting wall and objects in hallway and proceeded to room. CNA has went to resident room and during transfer back to wheelchair, unpredictable quick transfer by resident, (he) missed wheelchair and sat on floor, no injury, however note severe tight spasming of both left arm and left lower extremity, resulting in left lower extremity rigid and straight, unable to adjust to within normal limit positioning."

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R2's Nursing Progress Notes, authored by V11, Registered Nurse, document the following:
1/27/25 at 6:00pm: "(R2) has come to desk with request for CNA/toilet. Advised CNA will be available when current resident care completed. Demonstrates anger stating "I've been waiting for 45 minutes." Advised that he has just left dining area a few minutes ago, anger has escalated and spun wheelchair around, hitting wall and objects in hallway and proceeded to room. CNA has went to resident room and during transfer back to wheelchair, unpredictable quick transfer by resident, missed wheelchair and sat on floor. No injury, however note severe tight spasming of both left arm, and left lower extremity, resulting in left lower extremity rigid and straight, unable to readjust to within normal limits positioning."
1/28/25 at 7:43am: "This nurse completed skin assessment today due to post fall status. Note light purple bruising along left lower rib cage. Palpated site with no abnormalities felt. No complaints of pain/discomfort during assessment, however resident has shared with CNA (staff) today that "my ribs and arm are broken." Reported to in house NP (Nurse Practitioner) earlier in shift with no orders received. No respiratory distress or difference in baseline abilities for repositioning/transfers were noted, administered 4:00pm hydrocodone and applied lidocaine patch over palm sized bruising of rib cage. In house NP (was) notified of resident continued complaints of soreness of this area and nursing measures completed at this time. Order received for x-ray of areas of concern (left arm and left rib cage)..."
01/29/2025 at 06:29pm: "Radiology results received, abnormal findings are acute nondisplaced left lateral 8th rib fracture, (and) suspected inferior subluxation of left shoulder. All other results are negative for findings. Abnormal

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findings reported to (V2, Director of Nurses) and in house NP for follow up this afternoon. (R2) has had no reports of increased pain or discomfort."

R2's 1/29/25 X-ray Patient Report documented, :"Left clavicle: Suspected inferior subluxation of the (left) shoulder," and, "Acute non-displaced left lateral rib fracture."

On 3/6/25 at 10:25am, R2 was alert but oriented only to self and could not give the name of the facility, current president, or the date. When R2 was asked if he remembered his 1/27/25 fall, he stated, "Yes, I was in the bathroom with the CNA going from the toilet to the wheelchair and she did not lock the brakes and the wheelchair slid, and I fell." R2 stated he could not remember the name of the CNA or anything about her.

On 3/11/25 at 9:00am, V11 stated R2's fall on 1/27/25 happened about 6:50 pm. V11 stated she was sitting at the nurses station charting when R2 approached, upset and yelling that he needed to go to the bathroom. V11 stated this behavior is typical for R2. V11 stated she asked him to go to his room and a CNA, whom she believes was V12, CNA, would be down there as soon as possible. V11 stated less than 5 minutes elapsed when V12 went to the room. V11 stated the next thing she knew, V12 notified her that R2 fell while getting off the toilet. V11 stated when she responded and went to the room, the wheelchair had been tipped on its side and the brakes were locked. R2's left leg and left arm, which is the side affected by his previous stroke, were very stiff. V11 stated when R2 gets agitated and mad, his left arm and leg will stiffen. V11 stated she assessed R2 and found no injuries, and R2 stated he was not hurt. V11 stated she notified V15, Nurse Practitioner, who gave no new orders.

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V11 stated when she worked with R2 on the following day, he had begun complaining about pain in his left shoulder and left torso and had a palm sized bruise to the left torso. V11 stated she notified V15 who ordered x rays. V11 stated the X-rays revealed a fractured rib and dislocated left shoulder.

On 3/11/25 at 10:25am, V12 stated R2 is impulsive with low frustration tolerance and has a history of falls, some of which were related to attempting to self transfer. V12 stated R2 requires the assistance of one staff for transfers and, "Is pretty easy to transfer, unless he is mad." V12 stated at the time of the fall, R2 was angry and agitated. V12 stated when she went to R2's room, he was already sitting on the toilet, having been transferred there by V13, CNA. V12 stated she waited outside the bathroom door as R2 does not like having staff in the bathroom with him. V12 stated R2 said he was finished, so she opened the door in time to see him falling, with the left side of the wheelchair rolling out from underneath him as the right brake was locked, but the left one was not. V12 stated if it had been locked, it probably would have prevented the fall. V12 stated she immediately notified V11, and R2 stated he was not injured.

On 3/11/25 at 11:10am, V13 stated she did not recall the events on 1/27/25 and is not sure if she transferred R2 onto the toilet or if she did or did not lock the wheelchair brakes.

On 3/11/25 at 11:45am, V16, Licensed Practical Nurse/Minimum Data Set Coordinator, stated R2 requires one staff for transfers, or two staff if he is having behaviors.

On 3/11/25 at 12:30pm, V2, Director of Nurses,

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stated staff should have made sure the wheelchair brakes were locked. V2 stated R2 may have needed two staff for the transfer, or staff could have waited until he was more calm to put him on the toilet. V2 stated R2 does not like having staff in the bathroom with him, and the intervention of staying in the bathroom with him should be removed.

On 3/11/25 at 3:00pm, V15 stated as a result of the fall, R2 sustained a rib fracture and shoulder dislocation, for which she referred him to an Orthopedic Surgeon. V15 stated R2 has refused to go to that appointment.

2. R3's Face Sheet documented an Admission Date of 10/11/22 and listed Diagnoses including Cerebral Palsy and Hypertensive Heart Disease Without Heart Failure. R3's MDS dated 11/28/25 documented that R3 has no deficits in cognition. The same MDS documented that R3 requires substantial/maximal assistance for transfers.

R3's Fall Risk Assessment dated 1/20/25 documented that R3 is at high risk for falls. R3's 1/20/25 Transfer Assessment documented that R3 requires one staff and a gait belt for transfers. R3's 3/6/24 Care Plan documented a problem area, "Dependent for transfers," with corresponding intervention,"Staff assist with all transfers with Gaitbelt, CGA x1 (Contact Guard Assistance with one staff member), and 2WW (Wheeled Walker) after applying long socks and AFO (Ankle Foot Orthotic) to right leg."

R3's Fall Investigation dated 1/27/25 documented, "At approximately 8:40pm this shift, resident was being transferred to the bed per staff assist when her legs gave out and the resident had to be lowered to the floor per staff. No noted

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injuries at this time. Resident was not wearing shoes when legs gave out. Shoes need to be worn with all transfers."

On 3/7/25 at 8:45am, R3 was alert and oriented to person, place, and time. R3 confirmed she fell during a transfer on 1/27/25. R3 stated she was in the wheelchair coming back from the toilet, and an unknown CNA did not apply her shoes, long socks, or right leg brace before attempting to transfer her to the bed. R3 stated a walker was not used. R3 stated she reminded the CNA she was supposed to have those interventions in place prior to transferring, but the CNA said, "That's ok, we can do this." R3 stated as a result, her legs gave out and she began sliding when the CNA caught her with her leg and lowered her to the floor. R3 stated she was not injured.

On 3/7/25 at 1:35pm, V6, CNA, stated she was the staff member present wen R3 fell on 1/27/25. V6 stated she took R3 off the toilet and into the wheelchair. V6 stated she did not apply R3's leg brace, socks, or shoes prior to the transfer, nor did she use a gait belt or walker. V6 stated at the time of the fall, she was aware of these interventions being in place but she did not implement them. V6 stated R3's legs gave out and she began to slide, so V6 braced R3 against her leg and lowered her to the floor. V6 stated R3 was not injured.

3. R4's Face Sheet documented an Admission Date of 7/24/24 and listed Diagnoses including Parkinsons Disease and Neurocognitive Disorder with Lewy Bodies. R3's MDS dated 1/20/25 documented that R4 has moderate deficits in cognition and requires substantial/maximal assist for transfers.

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R4's Fall Risk Assessment dated 1/29/25 documented that R4 is at high risk for falls. R4's Transfer Assessment dated 1/20/25 documented that R4 requires the assistance of two staff and a gait belt for all transfers. R4's Care Plan dated 2/27/25 documented a problem area, " Resident at risk for falling,"with corresponding intervention,"Provide toileting assistance as needed."

A 2/27/25 Fall Investigation documented, "Resident was transferring to bedside commode with assistance for (CNA) Resident was almost to commode just adjusting to align (to commode) and lost his balance. Resident fell on side of bed and bedside table caught his fall. (CNA) lowered him to floor. Nurse assessed resident and during assessment noticed small abrasion to left shoulder, (and) small skin tear on an older healed wound on both left forearm and buttocks."

On 3/7/25 at 9:05am, R4 was alert and oriented to person and place but not time. When asked about the 2/27/25 fall, R4 stated there was one CNA, name unknown, transferring him from the recliner to the bedside commode using a gait belt, and, "She let go of the gait belt for whatever reason, and I lost my balance and fell." R4 stated he sustained a couple of skin tears but no serious injury.

On 3/7/25 at 11:20am, V6 stated on 2/27/25 at about 2am, she transferred R4 from the recliner to the bedside commode with a gait belt. V6 stated R4 required the assistance of one staff and a gait belt for transfers. V6 stated she put on R4's shoes and a gait belt and got him to a standing position and they started moving toward the commode. V6 stated she noticed his oxygen tubing was pulling, so she let go of R4, told him to

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stand still, and went to unplug the oxygen concentrator. V6 stated R4 began to fall, with the bedside table catching his fall, and she was then able to lower him to the floor. V6 stated after the fall, she was informed by the Therapy Department that R4 was to have been two assist for transfers.

On 3/11/25 at 12:30pm, V2 stated staff should always transfer all residents according to their assessed needs.

The facility's Safe Patient Handling Program Policy dated 9/8/23 documented, "To identify, assess, and develop strategies to control the risk of injury to residents, nurses and other healthcare 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. All resident care will be provided in a safe, appropriate and timely manner in accordance with the resident's Care Plan. All residents will be assessed by the facility for the need for assistance transfer activities, mobility,or repositioning."

(B)