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	IL6008874	A. BUILDING: _____ B. WING _____	C 01/22/2025

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CITADEL AT SAINT BENEDICT	6930 WEST TOUHY AVENUE NILES, IL 60714

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S 000	Initial Comments Investigation of Facility Reported Incidents of: 12/27/24/IL184364 10/20/24/IL183955	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 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	S9999		

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

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.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to develop and implement individualized plan of care interventions to reduce the risk of injury from falls. This failure affects two of four residents (R1, R2) reviewed for falls. These failures resulted in R1 being left unsupervised in the dining room and was later observed on the floor with an abrasion to the head. R1 was sent to the hospital and diagnosed with three compression fractures of the thoracic spine. These failures also resulted in R2 rolling out of bed, landing on R2's buttocks on the floor, and was subsequently diagnosed with a left comminuted hip fracture.

Findings include:

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The facility's policy titled accidents and incidents: supervision, investigating and reporting dated 11/2023 denotes in-part the facility provides an environment that is free from accident hazards over which the facility has control. The facility provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes identifying hazard and risk, evaluating and analyzing hazard and risk, implementing intervention to reduce hazard and risk monitoring for effectiveness and modifying interventions when necessary.

The facility's policy titled Fall management dated 2013 denotes in-part based on previous evaluation and current data the staff will identify interventions related to the residents' specific risks and cause to try to prevent the resident from falling and try to minimize complications from falling. This policy documents potential fall prevention interventions including, tab alarm for chairs, pad alarm for chairs, wedge cushions, dropping the wheelchair seat, anti-roll back device, anti-tippers for front and or back of wheelchair, pad alarm for the bed, low bed, floor mat beside the residents bed, scoop mattress, half side rails, non-skid socks, bedside commode, urinal at bedside, and frequent toileting.

1. R1's face sheet shows R1 has diagnosis of hemiplegia and hemiparesis following cerebral infraction affecting left non-dominant side, lack of coordination, cognitive communication deficit, other reduced mobility, muscle weakness, wedge compression fracture of first thoracic vertebra, wedge compression fracture of second thoracic vertebra, wedge compression fracture of third thoracic vertebra, adjustment disorders with depressed mood, unspecified dementia,

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glaucoma, history of falling.

R1's Minimum Data Set (MDS) dated 10/29/24 section C for cognitive patterns shows BIMS (Brief Interview of Mental status) score of 2 (cognitive impairments.)

R1's care plan dated 9/27/24 denotes R1 is at risk for falls r/t (related to) confusion and episodes of dizziness. R1 will have no major injuries r/t falls through next review. Interventions: assist resident with ambulation and transfers, utilizing therapy recommendations, determine resident ability to transfer, evaluate fall risk, dycem to chair, invite to participate tin group activities, resident up in chair for meals, encourage not to sit at edge of bed for meals.

The facility's final report to the department dated 10/24/24 denotes R1's diagnoses including unspecified injury of head, cerebral infract, hemiplegia and hemiparesis following cerebral infract, abnormalities of gait and mobility, generalized weakness, unspecified dementia with psychotic disturbance, history of falling. the resident stood and attempted to walk after her family left visiting her and she fell. She stated she was going home. The resident was sent to the local emergency department where R1 was evaluated and diagnosed with a closed fracture of the thoracic vertebral body. The resident may have tripped on the leg rest when she got up from the chair. The resident most likely had increased confusion due to a urinary tract infection and seeing her family most likely triggered her to want to go home to join them.

On 1/21/24 at 11:41am V1 (CNA-certified Nursing Aide) said he was monitoring the dining room on 10/20/24 after lunch. V1 said his assigned

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(unidentified) resident needed to go to the rest room and he escorted the resident to the restroom. V1 said he told an unidentified female aide to monitor the dining room, while he assists his resident. V1 said he thinks he yelled that out to someone. V1 said he didn't wait for the aide to come and monitor the dining room before he left the dining room. V1 said he don't know if the aide went to monitor the dining room. V1 said he didn't ask the Nurse to monitor the dining room before he left the residents alone. V1 said he was made aware that R1 had a fall and another staff found R1 on the floor in the dining room. V1 said the purpose of monitoring the dining room is to assist the resident that may need help, get water, to watch the resident that may try to get up, monitor the residents that are at risk for falling and to take care of the resident's needs.

On 1/21/25 at 11:30am V4 Licensed Practical Nurse (LPN) said she was summoned to the dining room and she observed R1 laying on the floor on her back, the wheelchair was not far from R1. V4 said she assessed R1's level of consciousness and R1 had an abrasion to R1's head. V4 said she called 911 to escort R4 to the hospital. V4 said V1 did not ask her to monitor the dining room when he left the dining room. V4 said she don't recall R1's family visiting.

On 1/21/25 at 11:56am V5 (Director of Nursing) said she completed the fall investigation for R1. V5 said R1 was at risk for falls, R1 had prior history of falls. V5 said the root cause of R1 fall on 10/20/24 was that R1 was confused, wanted to go home, and she stood up from her wheelchair and fell. V5 said there was no staff in the dining room to intervene/assist when R1 stood up from her wheelchair. V5 said the dining room was not being monitored when R1 fell. V5

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said R1 had a BIMS score of 2 (cognitive impairments), poor safety awareness, dementia, and history of stroke.

R1's fall risk assessment dated 10/2/24 denotes R1 is alert and oriented x3, and no is checked for predisposing condition. V5 said R1's fall risk assessment is not accurate because it does not capture all of R1's fall risk factors. V5 said the nursing staff needs more training on documentation.

2.R2's face sheet shows R2's diagnoses including fracture of left pubis ramus, aphasia following cerebral infraction, need for assistance with personal care, unspecified dementia and repeated falls.

On 1/17/25 at 12:30pm V3, Registered Nurse (RN) said he was doing resident rounds and observed R2 rolling out of bed, V3 said he was able to hold R2 upper body but R2's buttocks landed on the floor. V3 said R2 was squirming/moving about in the bed. V3 said he don't recall a floor mat in place at the time of that fall next to R2's bed. V3 said the bed was lower, but not in the lowest position to the floor. V3 said he could not recall if it was reported to him that R2 had a current pelvic fracture. V3 said R2 denied he was in pain. V3 said he don't know why R2 was moving around in bed. V3 said R2 was not self-transferring when he fell as documented in the incident report and V3 does not know who documented that R2 was self-transferring when R2's fall occurred on 12/27/24.

On 1/17/25 at 1:17pm V5 (Director of Nursing) said she completed the investigation for R2's fall on 12/27/24. V5 said R2 is at risk for falls and R2 was admitted for rehabilitation after falling at

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home. R2 had a pubic ramus fracture upon admission. V5 said she doesn't recall inquiring about R2's previous fall with R2's family. V5 was asked if there were interventions in place to reduce further injury for falls for R2. V5 said R2's interventions were for the bed to be in lowest position, call light in place, call don't fall was to be in place when R2 returned from hospital after the fall. During a follow up interview V5 said putting the bed in the low position was not an effective intervention in reducing further injury for R2. V5 said the root cause for R2's fall was that R2 overestimated his abilities. V5 said she made notations in R2 records of R2 was self-transferring based on V3's description when she interviewed V3.

R2's hospital records dated 12/30/24 denotes R2's computed tomography (CT) scan of the pelvis shows a new comminuted displaced fracture of the left hip.

R2's baseline plan of care (MDS Kardex Report) with admission date 12/26/24 denotes in-part short term memory; problem is checked, long term memory; problem is checked. Daily decision making; severely impaired is checked. Falls; major injury is checked, not steady during transitions/walking; moving from seated to standing, walking, turn around, surface to surface transfer are checked. V5 (Director of Nursing) presented the Minimum Data Set (MDS) Kardex report and identified the document as the baseline plan of care for R2. The intervention of bed in lowest position is not documented as an intervention on R2's base line or comprehensive plan of care.

R2's radiology service report dated 12/30/24 denotes, a left hip with pelvis 2 views radiology

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S9999	Continued From page 7 exam was performed with findings of an acute fracture of the greater trochanter, and a questionable nondisplaced fracture of the left superior pubic ramus laterally. Impression: acute left greater trochanter fracture. On 1/22/25 at 11:30am V7 (Consultant) said the Kardex is not the baseline care plan, it is a tool used by the facility. V7 said she will follow-up to determine if a baseline care plan was initiated and developed. V7 said its not accurate that the facility does not use floor mats as a fall intervention. The facility's baseline care plan policy with dated 4/2017 denotes in part a baseline plan of care, to meet the residents' immediate needs shall be developed for each resident with within 48 hours of admission. To assure the resident immediate care needs are met and maintained, a baseline care plan will be initiated within 8 hours and completed within developed within forty-eight hours of the resident's admission. The interdisciplinary team will review the healthcare practitioners' orders and implement a baseline care plan to meet the resident immediate care needs including but limited to, initial goals based on admission orders, physician orders, dietary orders, therapy orders, social services and additional recommendations, if applicable. (A)	S9999		