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	IL6002588	A. BUILDING: _____ B. WING _____	C 03/04/2025

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S 000	Initial Comments Investigation of Facility Reported Incident of 1/21/25/IL186725	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)3)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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain	S9999		

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of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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

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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 effectively supervise R1 to prevent a traumatic fall and thoroughly investigate a fall. This failure resulted in R1 striking R1's head on a closet door during a fall to the floor and sustaining a brain bleed requiring emergency medical evaluation and treatment at two hospitals. R1 is one of three residents reviewed for accidents in the sample list of three.

Findings include:

The facility Fall Prevention Policy (revised 11/10/18) documents the following: All staff must observe residents for safety. If residents with a high risk code are observed getting up, help must be summoned or assistance must be provided to the resident. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. The unit nurse will place documentation of the circumstances of the fall in the nurses notes or on an AIM for Wellness form along with any new intervention deemed to be appropriate at the time.

R1's Face Sheet dated 3/4/25 documents R1's diagnoses include: Cerebral Infarction, Mild Cognitive Impairment of Uncertain/Unknown Etiology, Muscle Wasting and Atrophy, Unsteadiness on Feet, Lack of Coordination, and Abnormalities of Gait and Mobility.

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R1's January 2025 Physician Orders documents an order for Xarelto (anticoagulant) 2.5 milligrams by mouth twice a day.

R1's Comprehensive Assessment dated 1/7/25 documents R1 is cognitively intact with no upper or lower limb impairments, uses a wheelchair and/or walker for mobility, and requires partial/moderate assistance with toileting and transfers.

R1's Care Plan (January 2025) documents R1 is high risk for falls related to gait/balance problems and requires assistance to transfer. This same record documents R1 had a fall on 1/5/25 due to unsteady gait with root cause of R1 having increased confusion, trying to reach for tray and slipped out of R1's recliner. Further documents R1 had a fall on 1/21/25 with root cause of R1 confused, tried to stand up unassisted, lost balance and fell. Intervention: Educate resident on the importance of calling for help when transferring from recliner.

R1's Nursing Progress Note dated 1/22/25 at 3:30pm, documents R1 complained of being tired and documents R1 "has been more lethargic today." Further documents V4 R1's Representative at facility to visit R1 and R1 reporting to V4 that R1 did hit head [during fall on 1/21/25]. Further documents Emergency Medical Services (EMS) notified and R1 sent to local emergency department for evaluation and treatment.

R1's Emergency Department Report dated 1/22/25 documents the following: Chief Complaint: EMS reports patient [R1] fell last night hitting back of head on cubbie. Complains of 7/10 head and neck pain. Patient had stroke one

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month ago and still taking thinners for AFIB.
ED Course: Patient is presenting for an unwitnessed fall last night that occurred around 10:30pm. Patient is complaining of headache and reports hitting the back of head. No palpable hematoma or signs of significant head trauma. Patient is slow to respond and somnolent. Mild dysarthria (a speech disorder characterized by difficulty in speaking clearly due to damage or dysfunction in the muscles or nerves that control speech. Dysarthria can be caused by strokes.) Stroke about one month ago. On Xarelto for A-fib and the prior stroke.
Disposition: Transfer to (higher level of care) trauma facility.
Assessment: 1. Subdural hematoma, acute 2. Unwitnessed fall 3. Chronic anticoagulation.

R1's Computed Tomography of Brain/Head dated 1/22/25 documents the following: Reason for exam: Fall, slurring. Impression: New mild hyperdensity along the falx concerning for minimal acute subdural hemorrhage.

R1's Incident Investigation Form completed by V3 Agency Licensed Practical Nurse (LPN) on 1/23/25 documents R1 had an unwitnessed fall on 1/21/25 at 10:30pm and R1 was found on the floor in R1's room lying on R1's left side. This same record documents R1 denied "hitting head."

R1's Fall Investigation dated 1/23/25 documents R1 had an unwitnessed fall on 1/21/25 with increased confusion noted on 1/22/25. Further documents R1 sent to local emergency department on 1/22/25 and diagnosed with a subdural hematoma.
V5 Certified Nursing Assistant (CNA) statement dated 1/25/25 documents the following: R1 had an unwitnessed fall on 1/21/25 at 10:30pm and

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R1 was on the floor at the end of R1's bed and appeared to have hit R1's head on the closet door. Further documents V3 Agency LPN asking R1 if R1 "hurt anywhere" and R1 stating "bottom and head." V5's statement documents R1 receiving a phone call on R1's cell phone from the local police department regarding a call R1 had placed claiming someone was breaking into R1's apartment. Further documents R1 being confused during this incident.

R1's Quality Care Reporting Form, Investigative Report for Falls, AIM for Wellness (all part of the facility fall packet), and Nursing Progress Note related to R1's 1/21/25 fall was not completed by V3 until 1/23/25.

On 2/28/25 at 11:46am, V4 R1's Representative stated R1 had a stroke on 12/21/24. V4 stated R1 uses walker to ambulate and was trying to get out of bed thinking someone was breaking into R1's apartment. V4 stated R1 called the local police and the police went to R1's apartment then came to facility after calling R1's cell phone. V4 stated V4 came to facility around 3:00pm on 1/22/25 and R1 was slurring R1's speech. V4 stated R1 was sent out at this time for evaluation and treatment at local emergency department. V4 stated R1 was transferred from the local emergency department on 1/22/25 to a higher level of care hospital.

On 3/4/25 at 10:18am, V7 LPN stated V7 worked during the day on 1/22/25 and took report from V3. V7 stated V3 advised R1 had fallen. V7 stated V3 advised V7 that R1 landed on R1's bottom and had no injuries. V7 stated V7 was unable to locate the fall packet for R1. V7 stated R1 on 1/22/25, appeared per norm, talking, took medications without issue and R1 stated, "'tired,

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kept up all night.'" V7 stated the procedure for after a resident fall is to assess the resident, fill out the fall packet, and if on blood thinners (anticoagulant) or the resident hit their head, automatically send resident out [for evaluation and treatment]. V7 stated neurological checks are initiated and the resident is also monitored throughout the day.

On 3/4/25 at 1:17pm, V5 CNA stated V5 didn't usually work over on R1's side of the facility but was familiar with R1. V5 stated R1 was not usually confused. V5 stated R1 is usually "with it" and talks to "a lot of people." V5 stated V3 and V5 were at the nurses desk on 1/21/25 and heard a loud noise down the 100 hallway. V5 stated V3 was in front of V5 when they arrived at R1's room and R1 was on the ground with R1's head near closet door and R1's wheelchair was right beside R1. V5 stated R1 had one sock on and one sock off. V5 stated R1 stated, "'I'm letting the cops in'" (from the closet door). V5 stated V3 assessed R1. V5 stated during this time R1 received a phone call from an unknown number on R1's cell phone and R1 answered the call and it was the local police department. V5 stated V3 asked R1 if R1 hit R1's head or if anything hurt and R1 stated R1 hit R1's head. V5 stated they assisted R1 back into R1's wheelchair and then bed. V5 confirmed R1 was not sent out for evaluation and treatment at that time. V5 stated after the fall, R1 was very confused and unaware of who staff were and was frightened. V5 stated R1 was one assist with supervision and needed help with toileting and transfers. V5 stated any residents with unwitnessed falls and/or hit their head were usually sent out for evaluation and treatment.

On 3/4/25 at 2:24pm, V10 CNA stated stated R1 was one assist but known to get up per self and

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S9999	Continued From page 7 R1 would transfer from recliner to R1's bed without notifying anyone. On 3/4/25 at 2:30pm, V2 Regional Director of Nursing stated V3 Agency LPN should have completed the fall packet and reported R1's 1/21/25 fall on 1/21/25. V2 confirmed the fall packet was not completed until 1/23/25. (A)	S9999		