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| S 000 | Initial Comments<br><br>Complaint Investigation 2553810/IL191326 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210a)<br>300.1210b)<br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 and psychosocial needs that are identified in the | S9999 | | |

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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.

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.

Thesee regulations were not met as evidenced by:

Based on interview and record review, the facility failed to ensure necessary supervision was provided to prevent a fall with injury for 1 (R1) of 3 residents reviewed for accidents and supervision. This failure resulted in R1 being found in the floor

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resulting in mildly displaced left lateral sixth and seventh rib fractures and an acute, mildly displaced, and angulated fracture of the left femoral neck.

Findings include:

R1's Admission Record documents an admission date to the facility of 3/16/25 with diagnoses including displaced intertrochanteric fracture of right femur, altered mental status, unspecified, alzheimer's disease, unspecified and dementia in other diseases classified.

R1's Minimum Data Set (MDS) dated 3/20/25 documented R1 had a Brief Interview for Mental Status (BIMS) score of 3, indicating R1 had severe cognitive impairment. The same MDS section GG documents that R1 has impairment in both sides of upper extremities (shoulder, elbow, wrist, hand) and impairment on one side for lower extremity (hip, knee, ankle foot) and uses a wheelchair as a mobility device.

R1's Care Plan documented a focus area of R1 at risk for falling related to alzheimers disease/dementia, with interventions including observe frequently and place in supervised area when out of bed.

On 5/2/25 at 9:40 AM, V3 (Family) stated R1 had been transferred to this facility for rehabilitation after a fracture to her right femur. V3 stated R1 had 4 falls within one month time frame that she had been in the facility. V3 stated R1 had been significantly injured in two of the falls that included a laceration to the lip and fracture to the left hip. V3 stated he did not receive any communication from the facility on R1's fall on 4/4/2025 when she had been transported to the local hospital.

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| S9999 | Continued From page 3<br><br>On 5/2/25 at 10:49 AM, V11 (Certified Nurse Assistant/CNA) stated she was familiar with R1 and has cared for her. V11 stated R1 did have multiple falls while in the facility. V11 stated R1 did have a habit of trying to get up from her wheelchair without assistance.<br><br>On 5/2/25 at 10:58 AM, V5 (Registered Nurse/RN) stated he was familiar with R1 and has cared for her. V5 stated R1 had a habit of trying to stand up from her wheelchair and had been at risk for falls. V5 stated R1 should not be out of staff's line of sight because of her impulsive behavior of trying to stand without assistance anytime she was in her wheelchair. V5 stated nurses are to report to another nurse when they are leaving the unit floor and CNA staff are to report to the nurse when they are leaving the unit floor so there is coverage. V5 stated, he had never had 2 staff members off the unit floor together, it should always be a rotation.<br><br>On 5/2/25 at 10:59 AM, V9 (Nurse Practitioner/NP) stated, she did have direct patient care with R1. V9 stated R1 was confused and always trying to stand up from her wheelchair without assistance. V9 stated, that R1 needed constant care and if you took your eyes off of her, she would attempt to get up out of her wheelchair. V9 stated she had observed multiple times staff redirecting R1 when she would try to stand without assistance.<br><br>On 5/2/25 at 11:20 AM, V8 (Physical Therapy Assistant/PTA) stated, she did have direct care with R1. V8 stated she provided services to R1 that included ambulation, balance, walking and strengthening. V8 stated R1 was very confused most of the time and did attempt to stand on her | S9999 | | |

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own frequently from her wheelchair. V8 stated R1 did have mulitple falls while in the facility. V8 stated R1 needed a lot of verbal cues during therapy, but would respond to them. V8 stated R1 was a fall risk and should not have been out of staff sight. V8 stated, on 4/4/2025, V6 (CNA) came to the physical therapy room to ask her to stay with R1 who had fallen in the dining room.

On 5/2/25 at 12:07 PM, V7 (CNA) stated he didn't normally work with R1 and had been pulled from his usual unit to work R1's unit/hall on 4/4/2025 when R1 had been found in the dining room floor. V7 stated V4 (Licensed Practical Nurse/LPN) had left R1's unit/hall (where she was assigned) to go to a different hall in the facility for a few minutes sometime after 1:00 PM. V7 stated R1 had been sitting at the dining room table with another resident when he also left the unit to go to his car outside the building to get his vital sign equipment and was gone for about 5 minutes. V7 stated he did not notify anyone that he had left the hall to go outside. V7 stated it is the facility process for CNA's to notify the nurse when leaving the floor to help make sure the floor has coverage. V7 stated there was no staff member in the dining room with R1 when he left. V7 stated when he was walking back down the hallway with V4 (LPN) around 1:14 PM when V6 (CNA) notified them that R1 had been found in the dining room floor.

On 5/2/25 at 12:13 PM, V6 (CNA) stated, on 4/4/25 she had been working on R1's unit. V6 stated she had been pulled to work R1's hall that day, however, does not normally work there. V6 stated she had been in another resident's room when she heard yelling "help, help, help" around 1:14 PM. V6 stated when she went out to the dining room, R1 was lying on the floor and no

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other staff was present. V6 stated she asked V8 (Physical Therapy Assistant/PTA) to stay with R1 while she notified V4 (LPN). V6 stated she had not been aware that V4 and V7 were off the floor. V6 stated it is the facility process for nurses to notify another nurse and CNA's to notify the nurse when leaving the floor to help with coverage on the unit.

On 5/2/25 at 12:55 PM, V4 (LPN) stated she had been working R1's unit hall on 4/4/2025. V4 stated R1 was at risk for falls and did attempt to stand without assistance, frequently. V4 stated she did leave the unit floor sometime after 1:00PM to get keys from another unit floor nurse. V4 stated she had not been aware that V7 (CNA) had left the unit floor after she had. V4 stated on her way back to the unit floor around 1:14 PM, she bumped into V7 heading back to the unit floor at the same time. V4 stated V6 (CNA) notified her that R1 had been found lying on the dining room floor.

On 5/2/25 at 2:25 PM, V2 (Director of Nursing/DON) stated R1 had been admitted to the facility as a fall risk. V2 stated there should be 1 nurse and 2 CNA's working each unit. V2 stated, if a nurse is leaving their unit floor they should notify another nurse in the building for coverage. V2 stated, if a CNA is leaving their unit floor then they should notify their nurse for coverage. V2 stated her expectation for staff is to follow facility process of notifying another team member for coverage when they leave the unit floor. V2 stated there should not be 2 teammates off the floor together.

On 5/6/25 at 9:02 AM, V13 (Assistant DON/ADON) stated the facility will have 2 CNA's and one nurse to each unit and then a float CNA

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for the building. V13 stated it is the process of all staff members to notify another teammate when leaving the unit floor for coverage. V13 stated there should not be 2 teammates off the floor at the same time.

R1's Fall Risk assessments dated 3/16/25, 3/17/25, 3/25/25, 3/27/25 and 4/5/25 all documented R1 was a high fall risk.

R1's "Progress Note" dated 3/25/25 at 2:17 PM documented "At 1310 (1:10 PM), this resident fell in the dining room. She was trying to get up and walk, lost her balance and fell. I and the CNA were not able to catch her. She hit her right arm with no injuries and good ROM (range of motion). Landed on her back. No injuries noted. Paperwork being done and notifications made."

R1's "Progress Note" dated 3/27/25 at 5:50 AM documented "Resident was sitting in a wheelchair at the sink in her bathroom brushing her teeth when she attempted to stand without assist. Resident was found in the floor, laying on her left side. No shortening or rotation to BLE (bilateral extremeties). Hematoma noted above the left eye. No other injuries observed. Resident placed back in wheelchair with assist x (times) 2. Spoke to (name of V9/NP). No new orders received at this time. She will be in this morning to assess Resident. Detailed message left with (name of V3/POA). Message sent through (name of messaging app) to notify Administration. Neuro's started. Fall report complete. Resident currently sitting in dining room watching television."

R1's "Progress Note" dated 3/31/25 at 11:00 AM documented "the resident was sitting in her wheelchair in her room prior to lunch. (Name) with activities witnessed the fall, she stated the

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resident stood up and fell face first hitting her head off the floor. Assessed resident no rom (range of motion) or shortening of extremities noted. She has a laceration to her top lip. Vitals are 146/78, P98, temp 98.3, R 20, o2 975 room air. She is stating that she is dizzy..." The progress note also documented a fall mat was placed in the resident room and bed in lowest position.

R1's "Progress Note" dated 04/04/25 at 1:31 PM documented it was recorded as a Late Entry on 4/4/25 at 4:01 PM by V4 (LPN). The progress note documented "Called to dining room at approx. 1:14 PM by CNA. Resident found to be laying in floor. Resident c/o (complained of) left hip pain. (Name of ambulance company) called to transport resident to (name of local hospital) for further evaluation."

R1's "Progress Note dated 04/04/25 at 4:01 PM documented "Called (name of local hospital) to follow up on resident. Nurse states patient will be admitted for fx (fracture) left hip. Nurse will call back with further details."

The facility incident report dated 04/04/25 documented V4 (LPN) had found R1 lying on the floor in the dining room. R1 had been identified of having poor safety awareness. The resident had been sitting at the table prior to fall with brakes to wheelchair locked. V4 stated wheelchair had been found with brakes unlocked and sitting behind resident.

Local hospital "History of Present Illness (HPI)" dated 04/04/25 at 2:16 PM documented under Chief Complaint: Patient presents with fall. This is reported to be (R1's) 3rd fall in 1 month. R1 had an unwitnessed fall. Two weeks ago, she fell and

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| S9999 | Continued From page 8<br><br>broke her proximal femur in right side. Then she fell and hit her face with sutures in the lips and third is left leg. This same document on page 8 documented a computed tomography scan dated 04/04/25 with results of mildly displaced left lateral sixth and seventh rib fractures and on page 9 under electromagnetic waves (X-ray) of the hip left included pelvis results of acute, mildly displaced, and angulated fracture of the left femoral neck.<br><br>The facility "Falls Management" (revised 4/21/2022) documented under Policy "it is the policy of (facility name) to assess and manage resident falls through prevention, investigation, and implementation and evaluation of interventions.<br><br>The facility staffing policy (revised 1/2023) documented under Policy, "The facility provides adequate staffing to meet needed care and services for our resident population and according to regulatory staffing requirements (CMS, IDPH)." Under Procedure, "1. Our facility maintains adequate staffing on each shift to ensure that that our resident's needs and services are met and schedules adequate staff to meet or exceed individual state requirement. 2. Licensed registered nurse and licensed nursing staff are available to provide and monitor the delivery of resident care services....3. Certified Nursing Assistants are available each shift to provide and monitor the delivery of resident care services of each resident as outlined on the resident's comprehensive care plan."<br><br>(A) | S9999 | | |