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S 000	Initial Comments Complaint Investigation: 2564407/IL192777	S 000		
S9999	Final Observations Statement Of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 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 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

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.

These regulations were not met as evidenced by:

Based on observation, interview and record review the facility failed to implement fall interventions resulting in a falls for three (R2, R12, R13) residents and failed to complete a resident fall assessment timely for two (R12, R13) residents out of three residents reviewed

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for falls in a sample list of thirteen residents. R2 fell at the facility resulting in R2 being sent to the emergency room and diagnosed with a Right Temporal lobe laceration requiring five staples and a Right Femoral fracture as a result of the fall which occurred in the facility. R2 experienced pain, discomfort and additional medical procedures due to R2's fall.

Findings include:

1. R2's undated Face Sheet documents medical diagnoses as Chronic Ischemic Heart Disease, History of Falling, Diabetes Mellitus Type II, Glaucoma Left Eye Severe Stage, Hypertensive Retinopathy Right Eye, Primary Open Angle Glaucoma Sever Stage Bilateral, Delirium, Anxiety and Chronic Obstructive Pulmonary Disease (COPD).

R2's Minimum Data Set (MDS) dated 4/1/2025 documents R2 as severely cognitively impaired. This same MDS documents R2 requires set up/supervision assistance with eating, bed mobility, dependent on staff for toileting, dressing and maximum assistance for bathing.

R2's Careplan intervention dated 4/27/25 documents requires assist by one staff for locomotion using wheelchair/walker. This same careplan includes fall interventions for the staff to ensure proper functioning and placement of an electronic bed alarm dated 4/21/25, fall mat next to R2's bed dated 4/21/25 and instructs staff to ensure R2's call light is within reach dated 6/7/24.

R2's Fall Risk Assessment dated 4/21/25 documents R2 as a risk for falls.

R2's Final Incident Report to the State Agency

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dated 5/12/25 documents R2 had an unwitnessed fall in the facility on 5/11/25 at 6:10 AM resulting in an acute angulated impacted fracture of the Right Subcapital Femoral neck. This same report documents "(R2)) is up with one assist. (R2) stated he was trying to go to the bathroom. (R2) requires supervision for transfers and ambulation. Call light was not activated at the time of the fall. (R2) is impulsive and does not always activate call light for staff assistance, (R2) diagnosed with acute angulated impacted fracture of the Right Subcapital Femoral Neck."

R2's Fall Investigation dated 5/11/25 documents staff heard a thud and R2 yelled out for help. This same report documents R2 was noted to be laying on the floor with his head over the bathroom floor with his pants around his lower legs. This same investigation documents R2 obtained a 2.5 centimeter (cm) laceration on the Right Side of his head with active bleeding, Right Upper Forearm measuring 2.8 cm long by 1.2 cm wide, Left Upper Forearm skin tear measuring 2.5 cm long by 3.0 cm wide. This same report documents R2 complained of Right Hip Pain. This same report documents R2 was assessed, then assisted to bed and then staff provided first aid for injuries sustained in fall. This same report documents R2's clothing was a predisposing factor in R2's fall.

R2's Transfer Form dated 5/11/25 documents R2 complained of 10 out of 10 pain from unwitnessed fall.

R2's Hospital Record dated 5/11/25 documents R2 presented to the emergency room due to a ground level fall at the facility resulting in hip pain at the facility. This same record documents R2 sustained abrasions to his forearms, a 3.0

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centimeter (cm) laceration to the Right Frontotemporal region which required five staples and a Right acute impacted Subcapital Femoral Neck Fracture.

R2's X-Ray of his Right Hip two-three views with Pelvis dated 5/11/25 document "Findings: Acute angulated impacted fracture of the Right Subcapital Femoral Neck."

On 5/27/25 at 10:35 AM R2's call light was laying on the floor next to his bed. R2's call light was out of reach. R2 did not have a fall mat visible in his room. R2 was not laying on a personal alarm. R2 had five staples in his Right Temporal lobe. R2 stated "My hip hurts so bad (as R2 was rubbing his Right Hip)."

On 5/27/25 at 1:40 PM R2 was laying on his back in his bed with his call light laying on the floor next to his bed. R2's call light was out of reach. R2 was not laying on a personal alarm. R2 did not have a fall mat visible in his room.

On 5/28/25 at 10:20 AM R2 was laying in his bed with his call light laying on the floor. R2's call light was out of his reach.

On 5/28/25 at 10:25 AM V6 Licensed Practical Nurse (LPN) stated R2 cannot reach his call light when it is laying on the floor. V6 LPN entered R2's room and positioned R2's call light.

On 5/28/25 at 11:25 AM V21 Registered Nurse (RN) stated she was R2's nurse on 5/11/25 the morning R2 fell. V21 RN stated R2 had an unwitnessed fall in his room while trying to use the bathroom. V21 RN stated
she found R2 laying on the floor with his head on the bathroom floor and the rest of his body laying

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in the room. V21 RN stated R2 was wearing cacky casual pants around his ankles. V21 RN stated it looked like R2 was laying in bed and had tried to get up and walk over to use the bathroom but tripped because his pants were around his ankles. V21 RN stated R2 did not have siderails in the up position and did not have a fall mat on the floor. V21 RN she heard a loud thud noise and immediately following, heard R2 yelling out 'Help!'. V21 RN stated R2 was sent to the hospital because of his injuries from his fall and the amount of pain R2 was having. V21 RN stated R2 rated his pain a 10 out of 10. V21 RN stated R2 showed signs of pain by grimacing and yelling out in pain.

On 5/28/25 at 12:00 PM V5 Certified Nurse Aide (CNA) stated R1 would not have been able to put his own pants on prior to his fall on 5/11/25. V5 CNA stated R1 would have been able to 'fidget' with his clothing but not able to get up out of bed, walk over to his closet, pick out a pair of pants, put his own pants on and then get back into bed just to get up again and fall. V5 CNA stated she had received report from the night shift staff and was told that they (staff) had put on R2's pants to help the day shift staff assist residents up quicker. V5 CNA stated it is common practice for the night shift to get some residents up or get some resident half dressed to make it easier on the day shift staff to get everyone up and to breakfast on time. V5 CNA stated when V5 arrived at work the morning of 5/11/25, R1 had already fallen and V5 saw that R1 had cacky colored casual pants on around his ankles.

On 5/28/25 at 12:50 PM V14 Assistant Director of Nursing (ADON) stated the staff should know the fall interventions for the residents or at least know how to locate the careplan. V14 ADON stated

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the fall interventions should be in place to help prevent a fall.

On 5/28/25 at 1:10 PM V26 Certified Nurse Aide (CNA) stated she worked the night of 5/10/25 into the morning of 5/11/25. V26 CNA stated she was not R2's assigned CNA but did help with R2's fall. V26 CNA stated R2 was laying on the floor in his room complaining of his Right Hip hurting. V26 CNA stated R2's head was bleeding enough the nurse (V21) had to apply pressure with a bandage. V26 CNA stated R2 had on 'regular' pants that were around his ankles.

On 5/28/25 at 1:45 PM V27 Medical Director stated if a resident falls, there should be a fall intervention put into place to help prevent further falls. V27 stated the staff should be following the resident's careplan and make sure that the fall interventions are in place. V27 stated R2's fall was preventable due to the fall interventions not being in place at the time of R2's fall on 5/11/25. V27 stated R2 was sent to the emergency room after his fall on 5/11/25 and diagnosed with a Right Femoral fracture and Right Temporal lobe laceration. V27 stated R2's family decided to not pursue a surgical option so R2 was sent back to the facility. V27 stated R2 will most likely be bedbound until he passes away. V27 stated R2 has had a general decline since his fall. V27 Medical Director stated the basic fall precautions typically instituted were not followed resulting in certain facility protocols not being followed which resulted in R2's fall with; major injuries.

The facility policy titled Fall Prevention Program dated 11/21/17 documents the facility fall program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate

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interventions to provide necessary supervision and assistive devices are utilized as necessary.

2. R12's Census Detail and Medical Diagnoses List, both dated 5/28/25, document R12 was admitted to the facility 6/4/24 with medical diagnoses including Parkinson's Disease, History of Falling, Difficulty Walking, Lack of Coordination, and Dementia.

R12's Fall Risk Assessments List dated 5/28/25 documents no Fall Risk Assessment completed from 9/22/24 through 3/1/25. R12's Fall Risk Assessment dates corresponded directly with the falls experienced by R12 documented in R12's Nurses Progress Notes and Initial Fall Occurence Notes dated 6/14/24, 6/26/24, 7/5/24, 8/13/24, 9/22/24, 3/1/25, 4/4/25, and 5/20/25.

The facility's Fall Prevention Program policy dated 11/21/17, provided by V2, Director of Nursing, documents fall risk assessments will be completed on admission, at least quarterly, after each fall incident, and with any significant change in status.

On 5/28/25 at 11:18 AM, V20, Director of Operations, stated she had checked with the Regional Nurse and the facility policy, and confirmed the fall risk assessments should be completed on admission, quarterly, after each fall, and with any significant change.

R12's Nurses Notes dated 5/20/25 document R12's wheelchair alarm was not sounding at the time of her fall on this date. R12's comprehensive Electronic Medical Record did not include any administration instructions, interventions, nor orders to check R12's alarm routinely.

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3. R13's Census Detail and Medical Diagnoses List, both dated 5/28/25, document R13 was admitted to the facility 10/5/23 with medical diagnoses including Depression, Bipolar Disorder, Vascular Dementia with agitation, and Delusional Disorder.

R13's Initial Fall Occurence Notes and Nursing Progress Notes, dated 5/15/25 document R13 exprienced a fall in her room on this date.

R13's Fall Risk Assessments List dated 5/28/25 documents no fall risk assessment completed from 10/8/24 through 2/21/25.

The facility's Fall Prevention Program policy dated 11/21/17, provided by V2, Director of Nursing, documents fall risk assessments will be completed on admission, at least quarterly, after each fall incident, and with any significant change in status.

On 5/28/25 at 11:18 AM, V20, Director of Operations, stated she had checked with the Regional Nurse and the facility policy and the fall risk assessments should be completed on admission, quarterly, after each fall, and with any significant change.

R13's Care Plan for fall prevention documents for R13 to wear non-skid type socks whether she is wearing tennis shoes or not, initiated 2/9/24. This same Care Plan documents R13 is to be assessed for fall risk per the facility policy. This Care Plan documents, in three separate focus areas, that R13 is a high risk for falls initiated 10/5/23, a moderate risk for fall initiated 2/20/24, and at risk for falls initiated 9/26/24.

On 5/28/25 at 12:30 PM, R13 was laying in bed

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S9999	Continued From page 9 wearing thick fuzzy regular socks which were not of the non-skid type. V24, Registered Nurse, stated and confirmed R13 should be wearing non-skid socks, as should all residents in the facility. V24 instructed V25, Certified Nursing Assistant to place the non-skid socks on R13. V25 confirmed R13 should be wearing non-skid socks. (A)	S9999		