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| S 000 | Initial Comments<br><br>Facility Reported Incident 6.17.22/ IL148182 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210 b)<br>300.1210 c)<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>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 | S9999 | Attachment A<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>care needs of the resident.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>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:<br><br>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.<br><br>These requirements are not met as evidenced by:<br><br>Based on interview and record review, the facility failed to accurately conduct a fall risk assessment to prevent accidental falls; failed to safely monitor a cognitively impaired resident at risk for falls and with a history of falls; and failed to train staff on fall precautions for residents. This failure affected 1 (R1) of 3 residents in the sample. This failure resulted in R1 being emergently transferred to the hospital with a femur fracture requiring surgical intervention.<br><br>Findings include:<br><br>R1 is a 74 year old cognitively impaired resident diagnosed with cerebral infarction, muscle weakness, difficulty in walking, aphasia, and displaced fracture of base of neck of right femur.<br><br>On 5/18/22 R1 was admitted to the facility by V8 (Agency Nurse) for short term rehabilitation due | S9999 | | |

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| S9999 | Continued From page 2<br><br>to ankle surgery after a mechanical fall and history of previous falls. V8 wrote in her admitting progress notes dated 5/18/22 at 6:49 PM which reads in part, "A female resident of 74 years old was admitted into the facility on stretcher from hospital. Resident was made comfortable in the room. Head to toe assessment was done. Resident has left ankle delayed wound healing has left ankle ORIF (open reduction internal fixation) surgery. Taking antibiotics every 24 hours for left ankle wound. Transfer with one person assist. Can only move bilateral lower extremities with one person assist."<br><br>V8's fall assessment showed however that R1 was assessed at a fall risk score of 3 showing no risk for falls although R1 had a history of falls and was admitted with an ankle fracture.<br><br>Interview with V2 (Director of Nursing) on 6/29/22 at 10:30 AM indicated that a fall risk score of 10 or above would mean a resident is at high risk for falls and a score of 3 would indicate no risk. Surveyor asked if R1 was considered high risk for falls, V2 stated, "I know she fell several times at the other facility and she fell here a month ago, so she is definitely high risk for falls." Surveyor asked if she knew who the admitting nurse was that inaccurately assessed R1 at a score of 3 meaning no risk for falls, V2 stated, "It was an agency nurse but that is an incorrect score. I will find out who the agency nurse is."<br><br>R1's initial care plan dated 5/18/22 reads in part, "(R1) is at risk for falls related to current medical condition, weakness, decreased balance/endurance, pain. Goal: (R1) will be free of falls through the review date. Interventions: Anticipate and meet the resident's needs; call light is within reach and encourage the resident to | S9999 | | |

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use it for assistance as needed. The resident needs prompt response to all requests for assistance; educate staff to assist patient to wheelchair after shower instead of sitting on toilet seat; Prepare all necessary all items before taking to shower.

Interview with V8 (Agency Nurse) on 6/29/22 at 4:50 PM stated, "I don't remember (R1) I work only agency there and I don't remember her. I worked different floors there (referring to the facility), but I work at a lot of different places too, so I don't know who that is." Surveyor asked if she was given any orientation to the facility's floor and units she worked on, V8 stated, "I think so." Surveyor asked what kind of orientation or training she received pertaining to the facility or floor, V8 stated, "They have me sign forms and stuff but not like I sit down and go through training. I bid for the slot and then I'm scheduled to work there, that is pretty much what happens. I don't get oriented to each and every resident. We kind of have to figure it out for ourselves. " Surveyor asked if she could recall whether R1 was a fall risk, V8 stated, "I'm not sure but most of those people there were fall risks I think." Surveyor asked if a patient came from the hospital with a fractured foot for example and had surgery on it whether that person would be at risk for falls, V8 stated, "Yes that would make them high risk for falls."

On 5/24/22 R1's initial fall in the facility was documented by V11 (PM Supervisor) who wrote in part at 6:10 PM: "Fall note. Called by one of the nursing aide to come to the room. She was on the floor, stating that she wants to go to the bathroom and find herself on the floor. Head to toe body assessment done, range of motion within normal limits. Denies any pain at this time. Denies hitting

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of the head. Assisted by 2 assist to sit up in the wheelchair with the use of gait belt. Toileted. educated to use call light for assistance."

On 6/17/22, R1's second fall in the facility was documented by V5 (Licensed Practical Nurse/LPN) wrote in part, " Incident Summary: Prior incident around 7 PM , resident was sitting on the wheelchair comfortably. Around 7:45 PM, nurse on duty was called by certified nursing aide that resident slid down from the toilet seat on the floor in lying position. Resident stated that I was trying to get up from toilet seat without assist and I lost my balance and I slid down from the toilet seat on the floor. Resident noted alert and oriented with periods of confusion. Resident was transferred to bed via mechanical lift assisted by 2 nursing staffs. Neurological checked initiated. Resident c/o pain 4/10, and Tylenol 1000 mg given. No bump or bruises noted at that time. Doctor from on-call notified and received order to x-ray for right thigh and neurological check. Daughter notified. Supervisor notified. Around 9:45 PM while doing assessment resident noted with disorientation with small bump on the head left side of the head and resident c/o pain on the Right hip. Nurse on duty called 911 immediately and send resident to hospital for further evaluation."

A written statement by V6 (Certified Nursing Aide/CNA) and taken by V5 dated 6/17/2022 at 19:45 reads "Per (V6-cna), the resident (R1) slid down from the toilet seat on the floor while I was turning to grab a hair dryer. Assessed the patient and the resident was transferred back to bed using a mechanical lift. Notified MD and family. Range of motion to all extremities with her baseline. Complained of pain 4/10, immobilized area, and applied ice. MD ordered stat X-ray,

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| S9999 | Continued From page 5<br>given Tylenol for pain."<br><br>A written and signed statement by V6 (Agency Certified Nursing Aide/CNA) dated 6/17/22 reads in part, "I had given the patient a shower. After drying and dressing the patient, I went to plug in her blow dryer with my back to the patient. In a matter of untangling the cord it was a big boom. I turned to look, and the patient was on the floor. I called for the nurse while trying to tell patient not to stand."<br><br>Interview with V5 on 6/28/22 at 11:00 AM stated, "I was the nurse taking care of (R1) and I was at the nursing station when V6 called me over and said R1 fell in the bathroom. V6 told me that she turned around and the resident all of a suddenly slipped off the toilet on her butt." Surveyor asked what he saw when he went into the bathroom and found her on the floor, V5 stated, "Her head was against the door and across from the toilet and V6 and another CNA who I can't remember the name picked her up and transferred her back to her wheelchair." Surveyor asked V5 to explain how R1 slipped off the toilet seat, but her torso and head were across from the toilet, V5 stated, "I don't know but you're right she must have fallen forward not backward if her head was towards the door." Surveyor asked if he questioned V6 further to get clarification, V5 stated, "No, I didn't do the investigation, but I did tell the supervisor that night." Surveyor asked when the supervisor came on to the scene to assess R1, V5 stated, "I paged her, but I didn't see her till later that night maybe around 9:00." Surveyor asked when R1 fell because he documented that R1 fell around 7:45 PM, V5 stated, "Sorry ,it was around 6 (PM) I think."<br>Surveyor asked if R1 was a fall risk and what fall preventative measures he took to keep her safe, | S9999 | | |

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| S9999 | Continued From page 6<br><br>V5 stated, "She is a fall risk I'm told, and I keep the bed very low and her call light by her." Surveyor asked if R1 was on any blood thinner medications, V5 stated, "I'm not sure." Surveyor asked if R1 was on any blood thinners, if R1 should have been sent out immediately, V5 stated, "I called the doctor-on-call that we use, and they did a video exam of her, but he only ordered stat x-rays." Surveyor asked whether he told his CNA if R1 was at risk for falls, V5 stated, "I don't remember telling her that, but she should have known."<br><br>Physician order sheet provided to surveyor on 6/29/22 showed R1 with two blood thinning medications.<br><br>Interview with V4 (Unit Manager) on 6/28/22 at 11:00 AM stated, "I talked to the CNA the next day because I wasn't working that day. I did the report because I'm the unit manager for the unit where R1 fell. V6 told me that the resident was on the toilet seat and V6 turned her back while she was trying to detangle the hairdryer and the patient suddenly got up. I think I heard the patient brought herself to the bathroom and I wasn't there. It was in the evening around 9:45 PM so I did the investigation the next day." Surveyor asked if she fell forward or backwards while on the toilet, V4 stated, "I was told she slipped off the toilet and she fell on her butt and the CNA was right next to her, but she turned around and the next thing you know the resident fell to the ground." Surveyor asked whether V6 may have left R1 by herself in the bathroom and left her unattended, V4 stated, "No she told me she just turned around and the resident fell." Surveyor asked if V6 actually saw R1 fall or whether the resident was already on the ground when V6 found her. V4 stated, "I was told she was in the | S9999 | | |

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bathroom with her, but she didn't actually see R1 fall but I wrote that it was a witnessed fall." Surveyor asked if the V6 didn't actually see R1 fall, how her incident report was considered a "witnessed" fall, V4 stated, "I thought because the CNA was still in the bathroom with R1, so we considered it a witnessed fall, but I see what you mean because V6 didn't actually see her fall but only heard a loud boom sound." Surveyor asked if she believed V6's explanation of the incident and why there were no more questions about the incident due to the nature of the fall, V4 stated, "Yes I asked both the resident and the CNA." Surveyor asked if she asked V6 why anyone would blow dry someone's hair while seated on a toilet seat with a wet shower floor several feet away, V4 stated, "I never thought of that."

6/28/22 interview at 11:30 AM with V6 stated, "Yes I was the CNA taking care of R1 when she fell in the bathroom. She was seated on the toilet and my back was to her because I was untangling her hairdryer because I had just finished giving her a bath and sat her on the toilet seat. I didn't see her fall, all I heard was a loud boom and she was on the ground. I called the nurse (V5), and he came right away, and we carried her out of the bathroom and put her on the wheelchair." Surveyor asked if she ever left R1 unattended, V6 stated, "No, like I said, my back was to her in the bathroom and the next thing you know is she was on the ground after I heard a loud boom." Surveyor asked if she was told R1 was at risk for falls, V6 stated, "No. No one told me she was a fall risk resident. I never took care of R1 before, and I was told to just give her a bath. Surveyor asked why she chose to blow dry R1's hair while she was seated on the toilet, V6 stated, "I don't know, she was already there." Surveyor asked if she had to obtain the

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dryer from the bedroom after R1 was finished showering and whether she left R1 unattended, V6 stated, "No I brought in all her supplies before I started the shower." Surveyor asked if she saw R1 fall, V6 stated, "Like I said all I heard was a loud boom sound and she was already on the ground." Surveyor asked how she slipped from the toilet, V6 stated, "She tried to get up I think, and she slipped back on her butt."

On 6/29/22 at 1:45 PM, V10 (R1's daughter) stated to surveyor, "I got texts from other relatives starting at 6:00 that the facility was trying to get a hold of me. (V10 showed surveyor texts of her phone which affirmed first text came in at 6:10 PM 6/17/22.) I was at an appointment and my phone was off so as soon as I turned my phone back on, I got these series of texts and voicemail from V5 (LPN) saying my mom fell in the bathroom. I got to the facility around 8 PM and my mom was already put in bed. I talked to V5 (LPN) and the aide (V6 Certified Nursing Aide/CNA) to ask what happened. V6 was very defensive and said she didn't know my mom was a fall risk and that (V5) the nurse never told her anything. V5 said the same thing that he did tell her and blamed the CNA for the fall. They didn't know anything about my mother." Surveyor asked if she saw the nurse come in to do any assessments of her mom, V10 stated, "No, V5 never did any neurological checks if that is what you're asking. I never saw that (V7-nursing supervisor) either until close to 9 (PM). I had to tell her that I wanted my mom sent out 911. Both V5 and V9 kept telling me she was okay and that they were waiting for the x-ray company to come out. Meanwhile my mother is still in pain, she kept pointing to her leg and her head; and they just kept saying they gave her Tylenol and to let it work. I said my mother is on blood thinners and I

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didn't want her to have a brain bleed because she just hit her head. I even pointed out the bump on her head. Both the nurse and the supervisor tell me that they didn't know she hit her head because no one saw her fall. I tell them if no one saw her fall and someone is complaining of headache wouldn't they send that patient out 911? They were clueless and I'm not even a nurse and I know that a patient should be sent out immediately. So, I said that if they didn't call 911, I would call to have my mom sent out is when they finally called the doctor again to send my mom out."

Hospital records show in part:

"Arrival 6/17/2022 22:47 (10:47 PM) Patient presents with fall, hip pain right. (R1) is a 74 year old female who has a history of CVA with left sided weakness with fall from nursing home. Patient had history left ankle injury status post open reduction internal fixation surgery with delayed wound healing. At nursing home for rehab and wound care. While there she had a mechanical fall while in shower today. She said she hit her head. No obvious swelling. Also complained of neck pain. Pt. is on Plavix (blood thinning medication). Main complaint is her hip pain on the right. No deformity of right leg. X-ray hip 2-3 views: Result date 6/18/22.

Impression: Acute subcaptital right femoral neck fracture. Recommend pinning right hip. Risks and benefits of surgery discussed, including but not limited to pain, bleeding, infection, nerve or blood vessel problems, blood clots, pulmonary embolism, catastrophic injury, loss of limb, loss of life, subsequent arthritis or need for further surgery. Patient wished to proceed with surgery.

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| S9999 | Continued From page 10<br><br>Hospitalist service is consulted by doctor for perioperative management. She was at Skilled Nursing Facility, getting out of shower, lost balance while putting on her pants, and fell. No reported loss of consciousness but she did hit the left side of her head against the wall. She reports immediate pain at the right hip. Patient is seen lying in bed with 2/10 pain at the surgery site."<br><br>Policy dated September 2021 titled "Fall Policy" reads in part, "This facility is committed to minimizing resident falls so as to maximize each resident's physical, mental and psychosocial well-being. While preventing all resident falls is not possible, it is this facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventative strategies and facilitate as safe an environment as possible. All resident falls will be assessed, and the resident's existing plan of care will be evaluated for needed changes. The information collected from all resident falls will be reviewed by the interdisciplinary team for possible changes in facility practices and procedures. Policy: a fall assessment shall be completed on each resident on admission, readmission, quarterly, any significant change, and with each occurrence of a fall. The fall risk assessment shall at a minimum include a history of falls, contributing factors, gait, balance, and medications. A resident who is identified on admission as high risk for falls will have the interdisciplinary plan of care include initial interventions to prevent injuries and falls occurrences. Procedure: For each resident fall, a facility incident report and fall risk assessment will be completed by the nurse or designee. Each resident fall episode shall be documented in the resident's clinical record. Fall investigation will be completed with the root cause analysis. The resident's plan of care shall be updated by the | S9999 | | |

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| S9999 | Continued From page 11<br>IDT based on the fall risk assessment and investigation if additional care interventions are necessary. If a resident fall requires the services of a physician, hospital or other service provider, the facility shall notify by telephone or fax the state department of public health within 24 hours."<br><br>(A) | S9999 | | |