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	IL6009765	A. BUILDING: _____ B. WING _____	C 02/07/2024

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S 000	Initial Comments Complaint Survey: 2460938/IL169429	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 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 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.	S9999		

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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 observation, interview and record review, the facility failed to identify a resident's fall risk by inaccurately completing the admission fall risk assessment, develop an at risk for falls care plan and implement fall prevention interventions, provide appropriate supervision and assistance to prevent falls, investigate falls and implement appropriate post fall interventions for two of three residents (R1, R2) reviewed for falls on the sample list of three. This failure resulted in a newly admitted resident (R2) not being identified as a fall risk therefore not having any fall prevention interventions implemented. R2 experienced daily falls, including a fall on 1/26/24 in which R2 sustained a facial laceration requiring closure with adhesive glue and strips at the Emergency Room.

Findings Include:

1. On 2/6/24 at 9:20 am, R2 was walking down hallway on the Dementia Unit, bent forward and leaning to the right, while holding onto the hand rail. R2 was repeatedly asking for help stating, "I

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need help, I don't know where my kids are." R2 had a scabbed laceration above the left eye brow but was not able to state what happened.

On 2/6/24 at 10:48 am, V2 AIT (Administrator in Training) stated R2 had a fall that was witness over the surveillance cameras by V16 BOM (Business Office Manager), which caused R2's eye laceration. V2 explained R2 "was a fairly new admission at that point, coming from another facility with a history of falls". V2 also stated R2 had experienced multiple falls since being admitted to the facility.

R2's ongoing Census documents R2 was admitted to the facility on 1/24/24.

R2's ongoing Diagnoses Listing documents the following diagnoses: Alzheimer's Disease, Vascular Dementia with Behavioral Disturbances, and Anxiety.

R2's Admission Assessment dated 1/24/24 documents R2 requires substantial/maximal assistance with moving from sitting to lying position and lying to sitting, partial/moderate assistance with moving from sitting to standing and for transfers, and has poor trunk control.

R2's Fall Risk Assessment dated 1/24//24 and 1/25/24 documents R2 is not a fall risk however the one dated 1/30/24 documents R2 is a fall risk.

R2's Progress Notes document the following:
1/24/24 at 3:42 pm - experienced a witnessed fall. R2 has a small bump on the head.
1/25/24 - experienced fall at approximately 6:40am. R2 was walking down the hallway, using the siderail with CNA (Certified Nursing Assistant) close by. R2's gait was unsteady and R2 was

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unable to keep balance and fell to floor.
1/26/24 - Staff reported witnessing R2 falling to the floor via video surveillance. Nurse and staff responded and noted R2 to be lying on the floor on R2's back with complaints of head pain and was noted to have a laceration with bleeding to above the left eye.
1/30/24 - observed R2 getting out of the recliner in the tv room, and when R2 stood up, R2 fell back on the foot rest and fell forward hitting R2's head on the left side above the eyebrow, where R2 had previously had steri-strips applied. The area had a small amount of blood, and pressure was applied with cold cloth, more steri-strips applied.

R2's Risk Management Notes for the above falls document the following:
1/24/24 - CNA called nurse to hallway due to witnessing R2 fall on the floor. R2 bumped R2's head and also received a small skin tear to the left forearm. CNA stated R2 had an unsteady gait and was unable to keep R2's balance. R2 was not able to explain what happened. Education provided to R2 and CNA's to try and prevent falls. There is no post fall intervention documented as being implemented.
1/25/24 - R2 was walking down hallway with a CNA close by. R2's gait was unsteady and R2 was unable to keep balance and fell to the floor. There is no post fall intervention documented as being implemented.
1/26/24 - nurse called to hallway for a witnessed fall of R2. R2 was lying on R2's back on the inlet of the doorway in the hallway. Staff had witnessed R2 ambulating and became unsteady falling in the hallway/doorway via camera observations. R2 noted to have a laceration above the left eye, actively bleeding with open exposure of epithelial tissue. R2 was only able to state area of pain, not

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what had happened. R2 was sent to the hospital and the laceration to the left eye was repaired with glue and steri-strips. There is no post fall interventions documented as being implemented. 1/30/24 - R2 observed getting out of the recliner in TV room, when R2 stood up, R2 fell back on the foot rest and fell forward hitting R2's head on the left side above the eyebrow, where R2 had previously had steri-strips applied. The area had a small amount of blood, and pressure was applied with cold cloth, and more steri strips were applied.

R2's medical record does not contain an at risk care plan for R2's fall risk upon admission.

R2's Care Plan dated 1/29/24 {4 days after admission and after the first fall} documents R2 has had an actual fall with minor injury due to cognitive impairment. R2 does not understand limits, is unaware of safety needs, and has poor balance. This care plan includes interventions of: 15 minute checks for two weeks, pharmacy consult to evaluate medications, provide activities that promote exercise and strength building where possible, provide wheelchair when unsteady gait and PT (Physical Therapy) for strength and mobility.

On 2/6/24 at 10:28 am, V2 stated that the fall care plan and interventions were completed on 1/29/24 explaining, after R2's first fall (1/24/24) therapy screened R2, after the second fall, V2 instructed staff to place R2 in a wheelchair due to weakness, after the third fall, pharmacy completed a medication review and after the 4th fall, R2 was placed on 15 minute checks.

R2's PT Plan of Care dated 1/29/24 documents R2 presents to skilled PT after suffering 1-2 falls

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per day since R2 arrived at the facility {5 days prior}. R2 resides on the locked Alzheimer's unit and is currently using a wheelchair for mobility due to multiple falls.

R2's PT notes dated 2/1/24 documents R2 requires support on the right side due to increased right side lean and wanting to reach out for wall rails. Fatigues quickly.

On 2/6/24 from 9:20 am - 9:32 am, and 1:15 pm - 1:31 pm, R2 was wandering/walking the hall's unassisted, bent over forward and leaning to the right. R2's gait was unsteady.

On 2/6/24 at 2:45 pm, V10 Agency LPN (Licensed Practical Nurse) stated R2 is suppose to have staff with R2 when ambulating, R2 is not to be ambulating independently.

On 2/7/24 from 5:10 am - 5:45 am, R2 was wandering/walking the halls unassisted, bent over leaning forward and leaning to the right. R2's gait was unsteady. On two seperate occasions during this time, V12 CNA and V13 CNA walked past R2 and did not assist R2 with ambulation or redirect R2 to sit down and not ambulate independently.

On 2/7/24 at 7:10 am, V15 CNA stated V15 was working on 1/25/24 when R2 fell. V15 explained R2 was not walking at the time, as the Risk Management Report documents but instead had been sitting in wheelchair and when R2 stood up, R2's foot hit the wheelchair wheel causing R2 to loose balance and fall. V15 stated V15 reported how the fall occurred to the nurse on duty.

On 2/7/24 at 7:25 am, V10 confirmed V10 filled out the Risk Management Report for R2's fall on 1/2/524 and explained V15 had reported that R2

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lost R2's balance and fell. V10 stated V10 does not recall V15 saying R2 had lost balance due to hitting R2's foot on the wheelchair wheel but V15 might have. V10 just assumed R2 had been walking and then lost balance due to R2's gait being unsteady.

On 2/7/24 at 7:35 am, V2 stated no investigations for root cause R2's falls were completed and that V2 came up with the interventions based off what the nurses wrote on the Risk Management Reports.

On 2/7/24 at 9:20 am, V2 confirmed R2's fall risk assessments dated 1/24/24 and 1/25/24 were not accurate as the medications that R2 takes, along with R2's known fall history would have made R2 a fall risk. V2 also confirmed R2 did not have a fall risk care plan implemented with fall prevention intervention implemented at the time of admission but should have.

2. On 2/6/24 at 9:40 am, R1 had a scabbed laceration over the right eyebrow, which was open to air. The entire right eye is surrounded with a purple bruise with a greenish colored bruise to the right cheek bone.

R1's IDPH (Illinois Department of Public Health) Notification Form dated 1/27/24 documents R1 was found on the floor next to R1's bed, bleeding from R1's head. R1 had a facial laceration that was closed with adhesives while at the hospital.

R1's MDS (Minimum Data Set) dated 11/1/23 documents R1 has severe cognitive impairments and requires set up assistance only for mobility.

R1's Care Plan dated 1/29/23 documents R1 had a fall with minor injury with an intervention for

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S9999	Continued From page 7 pharmacy to conduct a medication review. On 2/6/24 at 1:44 pm, V2 AIT (Administrator in Training) stated V2 did not conduct an investigation into R1's fall. Stated the new intervention of pharmacy doing a medication audit was V2's idea as V2 is the one that decides what interventions to put into place since the facility does not have a DON (Director of Nursing). V2 confirmed the intervention was not an appropriate intervention due to R1 rolling out of bed and that a medication review would not assist in preventing R1 from rolling out of bed again or keep R1 safe if it did happened again. The facility Fall Prevention Policy dated 11/10/18 documents the facility will provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. Upon admission, the resident's fall risk will be identified and appropriate interventions will be implemented for residents determined to be at high risk for falls. . If resident's are high risk for falls and observed up or getting up, help must be summoned or assistance must be provided to the resident. If a fall occurs, immediately after the fall, a huddle will be conducted to help identify circumstances of the fall and the unit nurse will place new interventions and new interventions will be written on the care plan. (B)	S9999		