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	IL6006555	A. BUILDING _____ B. WING _____	C 11/28/2018

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S 000	Initial Comments Complaint #1847316/IL107185 Statement of Licensure violations	S 000		
S9999	Final Observations Licensure 1 of 2 300.610a) 300.1210b) 300.1210d)5) 300.3240a) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to assess, and prevent the formation of pressure ulcers for 1 of 3 residents (R4) reviewed for pressure ulcers in the sample of 13. This failure resulted in R4 developing an facility aquired unstageable pressure ulcer to his left buttocks. Findings include: 1. R4's Braden scale for pressure ulcer risk, dated 7/13/18, documents a score of 19 (17-19 indicating moderate risk).	S9999		

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S9999	Continued From page 2 R4's Minimum Data Set, MDS, dated 10/16/18 documents total dependence and one plus person assistance for toileting. The MDS documented he was at risk for pressure ulcers but did not have any pressure ulcers when this assessment was completed. On 11/13/18 at 11:28AM R4 was lying in bed on right side facing the window. R4 had an unstageable pressure ulcer to his left buttocks which was circular in area with a yellow center and surrounded by red tissue. At that time, V3, Licensed Practical Nurse (LPN), stated R4 acquired the pressure sore at the facility. R4's AIM for Wellness sheet, dated 10/27/18, documents a change in R4's condition. The Sheet documents a pressure ulcer to R4's buttocks measuring 4 centimeter (cm) by (x) 7 cm redness with 2 cm x 2 cm necrotic area with 0.5 cm x 1 cm blister. Notes on sheet document cleanse daily apply calcium alginate cover with foam and paper tape. R4's Treatment record, dated 10/27/18 documents "Cleanse wound to l (left) buttock, apply calcium alginate, cover with foam and paper tape change q (every) day and prn (as needed)." Treatment Record documents change in treatment on 10/30/18 to wound debridement ointment to l buttock wound, cover with foam dressing every day and prn. Treatment record documents on 11/8/18 treatment change to Hydrogel to L buttock wound cover with foam dressing daily and as needed. Consultant Wound Physician's initial wound evaluation and summary, dated 11/6/18 documents R4 has an unstageabe (due to	S9999		

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S9999	Continued From page 3 necrosis) of the left buttock with at least 1 day of duration. The Summary documents "Stage 3 unstageable due to necrosis measurement of 1.4x1.8x not measurable cm. dry eschar, normal skin surrounding, no erythemia, non tender." Wound physician's s wound evaluation, dated 11/13/18 documents "(R4) has a stage pressure wound to the left buttock of at least 7 days duration. There is light serous exudate. Measurements 1.2x1x0.1cm." The Evaluation documents 10% thick devitalized necrotic tissue with 80% slough and 10% granulation tissue with no change in treatment plan. On 11/14/18 at 12:15PM per telephone interview, V5, Physician stated he would have expected staff to have noticed redness or an open area during bathing prior to the development of the unstageable pressure ulcer. On 11/14/18 at 1:10PM V2, Director of Nursing stated she would expect staff to notice a change in skin condition during bathing. The Facility Policy Pressure Sore Prevention dated revised 1/18 documents it is the facility's policy to provide adequate interventions for the prevention of pressure ulcers for the residents who are identified as high or moderate risk for skin breakdown as determined by the skin risk for breakdown assessment. The policy documents the following guidelines will be implemented for any resident assessed at a moderate or high risk; daily skin checks, care plan entry, turn and reposition every 2 hours. (B)	S9999		

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S9999	Continued From page 4 Licensure 2 of 2 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures: 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	S9999		

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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.
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to develop and implement progressive interventions for the prevention of falls for 2 of 3 residents (R1 and R3) reviewed for falls in the sample of 13.

This failure resulted in R1 falling and fracturing her hip and declining in ambulation status.
In addition, this failure resulted in R3 falling and fracturing her right humerus.

Findings include:

1. R1's Fall Risk Assessments dated 4/6/18 and 4/14/18 document a score of 19, 5/19 score of 21 and 6/23 score of 21. A high score of 10 or> indicates high risk for falls. All of the Fall Risk Assessments documented she had diagnoses of Alzheimer's and Cognitive Deficit/Dementia.

R1's Care Plan dated 3/26/18 documents for falls that R1 has risk factors that require monitoring and intervention to reduce potential for injury. Intervention dated 3/26/18 documents fall risk assessment quarterly and as needed.

R1's Situation Background Assessment

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Recommendation (SBAR) communication form dated 3/31/18 documents resident was walking with wheeled walker and lost her balance and fell backwards onto her buttocks. The SBAR documents she denies any complaints of pain and had no injury.

R1's Care Plan documents resident sustained fall on 3/31/18 with the root cause of fall as she lost balance. The Care Plan documented new intervention as 15 minute checks times 7 days.

R1's SBAR communication form, dated 4/6/18, documents R1 was found on floor in a room belonging to another resident. The SBAR documented she sustained no injury from this fall.

R1's Care Plan, dated 4/6/18, documents "resident sustained fall; root cause decreased cognition related to dementia diagnosis, new intervention: refer speech therapy for eval (evaluation) and treatment."

R1's SBAR communication from, dated 4/14/18, documents R1 was noted on the floor in another resident's room and her range of motion was within normal limits. The SBAR documented she was able to move all extremities no red or bruised areas noted.

R1's Care Plan, documents resident sustained a fall on 4/14/18. The Care Plan documented that the root cause was her shoes were untied. The intervention documented to encourage R1 to wear non-skid socks and attempt to get shoes that do not tie.

R1's SBAR communication form, dated 4/20/18, documents R1 was found sitting on her buttocks on floor by bed with walker in front of her.

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R1's Care Plan, dated 4/20/18, documents resident sustained a fall with root cause tripped on pant legs. The Care Plan new intervention was to get smaller pants and shorter.

R1's SBAR communication form, dated 5/12/18, documents R1 was ambulating with walker, noticed a limp L (LEFT) left. She denies pain in beginning after walker approx 10 ft (ft) as she refused to sit down, She is hold her low left back. "The SBAR Form documents physician notified and sent resident to emergency room. Hospital clinical report dated 5/12/18 documents no acute fracture. The Report documented "Clinical Impression: Single contusion to the left hip. Skin avulsion to left forearm."

R1's Care Plan dated 5/12/18 documents the root cause of R1's fall as unaware of safety needs. The Care Plan documented new interventions as "15 minute checks x 72 hours, then place hipsters on resident when she allows."

R1's SBAR communication form dated 5/19/18 documents R1 was lying on floor beside bed in room. The SBAR documented "Resident states 'I slipped out of bed.'" Form documents nickel sized skin tear to left elbow to be cleansed with normal saline and cover with Triple Antibiotic Ointment (TAO) and band aid daily until healed.

R1's Care Plan dated 5/19/18 documents resident sustained a fall with root cause unaware of safety, decline in cognition. The Care Plan documented the new intervention as "pressure alarm while in bed."

R1's SBAR Communication form, dated 5/25/18, documents nurse summoned to north hall where

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resident is lying on her back. No injury documented.

R1's Care Plan, dated 5/25/18, documents resident sustained a fall with root cause: decreased safety awareness decreased cognition. New Intervention: attempt to keep resident in high traffic area when awake.

R1's SBAR communication form, dated 6/1/18 at 2030 documented a fall with hip pain. Form documents "sitting on buttock on floor yelling out. Resident unable to move Left Lower Extremity (LLE)." The Form did not document if the resident fell while ambulating, in wheelchair on in bed. The Form documented she was sent to Emergency Room (ER).

R1's X-ray report, dated 6/1/18 at 9:59 PM, documents fracture proximal left femur.

R1's Care Plan, dated 6/1/18 documents resident sustained fall and the root cause was decreased safety awareness, decreased cognition and disease progression. The Care Plan documented new intervention as "apply dycem to w/c (wheelchair)."

R1's SBAR communication form dated 6/23/18 9:45 documents resident sitting in TV room floor in front of her wheelchair legs extended in front of her. Range of Motion (ROM) within normal limits except Left hip as previous fractured." The SBAR did not document if any staff were in the area as per care plan intervention of 5/25/18. The SBAR did not document if the Dycem was in the wheelchair at the time of this incident.

R1's Care Plan dated 6/23/18 documents resident sustained a fall with root cause as

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decreased safety awareness pressure pad alarm in w/c. The Care plan listed the new intervention as to keep her in high traffic area while awake although this was an intervention put into place on 5/25/18.

R1's SBAR communication form dated 9/7/18 documents resident on floor in the dining room. The form documents resident had a previous healing skin tear reopened. The SBAR documented the skin tear required Triple Antibiotic Ointment and steri strips. The SBAR did not document if this fall was witnessed or if she was being supervised.

R1's Care Plan dated 9/7/18 documents resident sustained a fall with root cause decreased safety awareness, decreased Cognition. New Intervention: evaluate for geri chair. There was no new intervention regarding increased supervision to prevent future falls.

R1's Minimum Data Set (MDS) dated 10/08/18 documents that R1 requires extensive assistance and two plus physical assistance for bed mobility and total dependence and two plus physical assistance for transfers. R1's MDS documents in part R1 has diagnoses of repeated falls and unspecified Dementia.

On 11/26/18 at 2:00 PM, V2, Director of Nursing (DON) stated that prior to falling and receiving a fracture R1 was able to walk, but is now wheelchair bound.

On 11/28/18 at 3:50 PM per telephone interview V22, Physician, stated that R1 is very demented. V22 stated that the fracture resulting from R1's fall has affected R1's quality of life. V22 stated with R1 being 91 years, any fall will affect R1's

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quality of life.

2. R3's Baseline Care Plan, dated 7/18/18 documents devise in use: "Pressure alarm." The form documents crawling from bed. New Intervention: low bed R3's Baseline Care Plan dated 7/18/18 documents a fall on 7/17/18. The Care Plan documents R3 leaning forward and recliner tipped with new intervention heavier chair and PT evaluate

R3's Fall Risk Assessment dated 7/13, 7/15, and 10/7/18 documents a score of 19, with a score of 10 or more being at high risk for falls.

R3's SBAR dated 7/17/18 documented she was found on floor in front of her recliner. The SBAR documented "Recliner noted tipped c (with) foot rest on floor."

R3's Baseline Care Plan was updated on 7/17/18 and documented "leaning forward in recliner tipped. N/I (New Intervention) - heavier chair and PT (Physical Therapy) eval."

SBAR communication form dated 7/22/18 documents fall, slid from recliner, no injuries. The SBAR did not document if the recliner noted in the previous fall was in use at the time of this fall.

R3's Baseline Care Plan documents an entry dated 7/25/18. The entry documented "Psych evaluation and monitor for 72 hours."

R3's MDS dated 7/27/18 documents R3 had long and short term memory problems with modified independence with decision making. R3 required limited assistance of one staff person for transfers and extensive assistance with ambulation. The MDS documented she was not

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steady and only able to stabilize with staff assistance with moving from seated to standing position, walking, turning around, moving on and off toilet and surface-to-surface transfers. The MDS R3 required supervision and setup only for bed mobility. R3's MDS documents in part a diagnosis of Dementia. The MDS documented she had sustained 2 falls without injury and 2 falls with injury since admission to the facility.

SBAR communication form dated 8/7/18 documents R3 slid from the wheelchair when trying to transfer to the couch. The form documents no injuries. The SBAR did not document any type of root cause analysis to determine the cause of this fall and what potential interventions could be used to prevent R3 from transferring self.

R3's baseline care plan documents intervention for 8/7/18 as "med review, possible mood stabilizer."

R3's Aim For Wellness form dated 10/5/18 at 2:00 PM documents "Heard resident's pad alarm, went to room and resident was sitting on her bottom on the floor. Tried transferring to recliner from wheelchair and got scared." This form did not document any root cause analysis as to how to provide increased supervision or address R3 from transferring self without assistance.

R3's AIM for Wellness form dated 10/7/18 documents "(R3) found on the floor on her buttocks." The form documents R3 complained of severe pain to right arm when touched yelled out loudly and would not move arm. The Form did not document where R3 was prior to being found on the floor. The Form did not document any type of root cause analysis regarding this fall.

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S9999	Continued From page 12 R3's X-ray report dated 10/7/18 documents Impression: Acute impacted /displaced fracture of the right humerus surgical neck. On 11/28/18 at 1:40 PM per telephone interview, V10/Certified Nursing Assistant (CNA) stated that he thought the nurse was the one who found R3 on the floor on 10/7/18. V10 stated at no time did he hear a bed alarm sounding. On 11/28/18 at 1:43PM V11, Licensed Practical Nurse (LPN) stated that she was on duty when R3 fell. V11 stated she heard R3 yelling for help and ran to R3's room and found R3 on the floor. V11 stated that R3's bed alarm was not sounding. On 11/28/18 at 1:45PM per telephone interview, V19 (CNA) stated that she was on duty when R3 fell on 10/7/18. V19 stated that V11, Licensed Practical Nurse (LPN) found R3 on the floor. V19 CNA stated that she was in another resident's room with V10, CNA. V19 stated that she heard V11 yell for help, and she and V10 responded. V19 stated at no time did she hear a bed alarm. The Facility Policy Fall Prevention dated, revised 11/10/18 documents to provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each residents desires for maximum independence and mobility. The policy documents appropriate interventions will be implemented. (B)	S9999		