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	6022178	A. BUILDING: _____ B. WING _____	09/15/2025

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A 000	Initial Comment Facility Reported Incident Investigation to incident of 08-28-25/IL197340. 295.4010 d) g) 1) A) C) h)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: T1 Violation Section 295.4010 Service Plan d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; C) special accommodations for the resident; h) The service plan shall include all support services provided or arranged for by the establishment. Based on interview, observation and record review, the establishment failed to ensure a resident identified risk for falls was documented	A4010		

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A4010	Continued From page 1 on the Service Plan for one of three residents reviewed (R3), and failed to ensure fall prevention interventions were documented on the service plan for three of three residents identified at risk for falls (R1-R3) that caused severe harm to a resident or creates a substantial probability of severe harm to a resident or residents. Findings include: On 09/11/25, E2 (Nurse Coordinator) provided a copy of the establishment's Resident Falls Handbook and explained that it is used throughout the entire campus. This handbook documents the following: Fall Prevention interventions: Whether you are at low, moderate or high risk for falling, interventions for prevention of falls and injuries will be added to your care (service) plan. These preventive interventions may require changes to your lifestyle, such as using a walker or a transfer aide. We value your preferences as much as your safety, and will be happy to discuss your individual fall prevention plan. Community staff members will also conduct timely rounding, based on your individual needs, to assist with your care and personal preferences." 1. R1's Resident Criteria (Admission Screening) Assessment (dated 04/24/25) documents the following under the section titled Risk for Falls: "A person's ability to ambulate or transfer without risk of fall or injury over the past 12 months: History of loss of balance or gait disturbance corrected by an assistive device or medications. Falls Service Planning- Focus: Falls. Goal: Will maintain free from falls while living in the community." This same assessment also documents the following under the section titled Mobility: Does the resident use any of the	A4010		

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A4010	Continued From page 2	A4010		

following assistive devices. Check all that apply: Walker. Assistive Devices Service Planning: Focus- Assistive Devices. Assistive Devices Tasks: Requires Reminders."

R1's Fall Investigation (dated 08/28/25) documents the following: "On 08/28/25 at approximately 4:00 PM, the resident (R1) exited the restroom within his apartment without the use of his walker to speak to an employee that arrived to provide a medication reminder. The employee witnessed (R1) turn and fall, hitting the back of his head on the floor. Nurse was notified. 911 was called and EMTs (Emergency Medical Technicians) assessed the resident and transported him to (local emergency department) for evaluation. POA (Power of Attorney) and MD (physician) were notified. He was intubated in the Emergency Department. Family elected to pursue comfort measures. The resident was noted to have an acute left subdural hematoma. He was later extubated at the emergency department and deceased at 08:00 PM on 08/28/25. Injury: Large Subdural Hematoma and significant brain bleed. Probable Cause: Resident was not using his walker for balance while ambulating in his apartment. He turned, lost his balance, and fell to the floor hitting his head."

R1's Most recent Physician's Orders document the following medication orders: Plavix (antiplatelet agent) 75 milligrams by mouth daily, and Aspirin (antiplatelet agent) 81 milligrams by mouth daily.

R1's 08/28/25 Progress Note documents the following: "RA (Resident Assistant) reported to nurse that resident had fallen. RA stated that she was checking on resident for dinner. Resident was in living room standing up without his walker,

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A4010	Continued From page 3	A4010		

turned, lost his balance and fell onto the floor, hitting the back of his head on the ground. Was wearing non-skid shoes. Walker was in his bathroom. Nurse assessed resident. Resident lying on the ground. Resident was confused but responsive and able to answer questions. Pupils small. Slightly sweaty. Back of head bruised but no open wound. Nurse continued to talk to resident to assess responsiveness. RA called 911 due to resident hitting head and signs of possible head injury. POA (Power of Attorney) also contacted. Did not assist resident up due to risk of injury. While waiting on EMS (Emergency Medical Services), resident became unresponsive and was no longer keeping eye contact with nurse or able to answer questions. Pulse palpated. Breathing shallow. AED (automated external defibrillator) brought in and placed on resident as a caution. No shock required. O2 (Oxygen) saturation WNL (within normal limits). EMS arrived and took resident to hospital. Son stated he will meet resident at hospital. Wallet with resident. Hearing aids and glasses left behind."

R1's most recent Service Plan documents R1 was assessed as independent with the following Activities of Daily Living: Bathing, Toileting, Transferring, Hygiene, Dressing, Mobility, Activities and Eating. R1's Service Plan also documents a Focus on Falls (initiated on 06/11/25) with the following Goal: Will maintain free from falls while living in the community. The corresponding section for interventions on R1's Fall Service Plan is blank and does not have any fall prevention interventions documented.

R1's (local hospital) Emergency Department records (dated 08/28/25) document the following: "Patient is a 95-year-old male with a medical

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A4010	Continued From page 4 history significant for CAD (coronary artery disease) status post recent balloon angioplasty, currently on Aspirin and Plavix and history of recurrent falls with prior history of brain bleeds who presented to the emergency department after a witnessed fall. Patient was initially noted with a Glasgow Coma Scale of 5 (indicates severe brain injury) and was intubated for airway protection by the emergency medicine physician. Patient was leveled to a trauma yellow and trauma team presented for further evaluation. Patient was noted to have a large Acute Left Subdural Hematoma with 2.7 centimeter of midline shift with herniation. Neurosurgery was consulted. Given the patient's age, large bleed, midline shift with herniation, and nonreactive of the other people's this was determined to be a non-survival injury. Of trauma and neurosurgery discussed these findings with the patient's family who elected to pursue comfort care. Patient was extubated in the emergency department and expired at 08:00 PM." On 09/11/25 at 09:45 AM, E2 (Nurse Coordinator/Registered Nurse) stated the following regarding R1's 8/28/25 fall at the establishment: "(E3, Resident Assistant) went in to give (R1) a medication reminder. (E3) opened the door and found (R1) standing in the living room of his apartment. When he turned, he lost his balance, fell and struck his head on the floor. He wasn't using his walker when he fell. It was found in his bathroom. Generally, (R1) was alert and oriented and was independent with mobility and he used a walker. He had fallen previously before moving in and had a history of sustaining a brain bleed with a fall. He had only lived at (establishment) for a couple of months and had not had any other falls while he was here."	A4010		

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A4010	Continued From page 5 On 09/11/25 at 10:45 AM, E3 (Resident Assistant) stated she witnessed R1 fall in his apartment on 08/28/25. E3 stated, "It was around 4:00 PM. (R1) had a medication reminder scheduled for that time so I went to his apartment and opened the door. I stood at the doorway, called out for him, and he came walking out of his bathroom. I asked him if he had taken his medications, and he told me he had. I looked down to note this in the tablet I was holding and from the corner of my eye I could see that he had lost his balance. By the time I got to him, he had already fallen. He was on the floor, and I went to get (E2, Nurse Coordinator/Registered Nurse) immediately. (R1) was a very independent person. He went to the gym multiple times throughout the day. He did most everything for himself. I know about all we did was change his bedding and we did his laundry." E3 stated she was not aware that R1 needed any type of reminder to use his walker, "He always had his walker with him. He had left it in his bathroom that day when I went to give his medication reminder." 2. R2's Resident Criteria (Admission Screening) Assessment (dated 05/14/25) documents the following under the section titled Risk for Falls: "Falls Service Planning- Focus: Falls. Goal: Will maintain free from falls while living at the community." R2's Fall Investigation (dated 08/31/25) documents the following: "On 08/31/25 at approximately 11:00 AM, (R2) was ambulating outside with another Assisted Living resident when she fell. EMTs (Emergency Medical Transport) assessed the resident and transported her to (local emergency department) for evaluation of right hand. Probable Cause: She tried to prevent another resident from falling with	A4010		

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A4010	Continued From page 6	A4010		

whom she was walking with which resulted in the fall. Injury: Dislocation of ring finger of her right hand. Intervention: Encourage resident to take scheduled walks outdoors with a caregiver. Social Services will follow up with family and update her service plan as appropriate."

R2's current Service Plan documents R2 was assessed as independent in the following Activities of Daily Living: Toileting, Transferring, Hygiene, Dressing, Mobility, Activities and eating. This same Service Plan documents a Focus on Falls (initiated on 05/21/25) with the following goal: Will maintain free from falls while living in the community. The corresponding section for fall prevention interventions is blank and does not have any fall prevention interventions documented.

On 09/11/25 at 02:25 PM, R2 was ambulating independently in her apartment. R2 was dressed, groomed and wearing a pair of tennis shoes. R2 had her left 3rd and 4th digits splinted together with two velcro straps and stated she had recently injured her fingers after falling at the establishment. R2 stated, "I was trying to catch my friend that was falling and ended up falling myself. Staff came to help right away. I had to go to the hospital to get looked at."

3. R3's Resident Criteria (Admission Screening) Assessment (dated 05/01/24) documents R3 was not at risk for falls at the time of this assessment.

R3's Fall Investigation (dated 08/22/25) documents the following: "At 04:15 AM, (R3) was found between her recliner and window. (R3) stated she got out from bed to go to her recliner to get more Oxygen from her machine in the living room by her recliner. (R3) tried to sit in

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recliner, as possible sliding to the floor. Resident didn't have non-skid socks or regular shoes on bilateral feet at this time." This same investigation documents, "Investigation: Resident Assistant found resident on floor in room between recliner and window. Resident was attempting to sit in her recliner and slipped. She was barefoot and not wearing any non-skid shoes or socks. No injuries. Assisted up with minimal assistance. Probable Cause: Resident was barefoot and lost her footing when trying to sit in her recliner. Intervention: Educated on wearing non-skid socks or shoes when ambulating and to use call light for assistance."

R3's Morse Fall Risk Scale Assessment (dated 08/22/25) documents R3 was assessed as a high risk for falling.

R3's current Service Plan does not have a focus in place addressing R3's risk for falls.

On 09/11/25 at 12:45 PM, E2 (Nurse Coordinator/Registered Nurse) stated the establishment does not do a formal fall assessment of their residents at the time of move-in, "We do ask if they have a history of falls within the past year on the Admission Screening and we will create a Service Plan regarding falls if the resident has a fall history. If a resident falls in the building, we complete a Morse Fall Scale Assessment after the fall. We do put a focus for Safety Checks on the Service Plan if needed, and most residents are checked once a day at breakfast." E2 then stated that R1 and R2 were identified as a Fall Risks upon their date of move-in at the establishment, and a focus specific to Falls was noted on their Service Plans. E2 also stated R3 was not identified as a fall risk upon her move-in date, but was later identified as

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A4010	Continued From page 8 a fall risk after she fell at the establishment. E2 verified that R3's Service Plan does not have a focus in place regarding falls or any fall prevention interventions documented. E2 then confirmed R1 and R2's Service Plans do not have any fall prevention interventions documented.	A4010		