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	ASL510362	A. BUILDING: _____ B. WING _____	C 10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 000	Initial Comment Facility Reported Incident of 10/18/2025/IL00198167 295.4010 a), b) 1), 2), 3), d), e), g) 1, A), C), 2), 3), 4), h)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident. 2) The manager or manager's designee; and 3) A registered nurse if the resident is receiving nursing services or medication administration or is unable to direct self-care. 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).	A4010		

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A4010	Continued From page 1 e) The service plan shall be reviewed and revised, if necessary, immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). 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. 2) The amount, type, and frequency of health-related services needed by the resident. 3) Staff responsible for the provisions of the service plan. 4) Any risk being negotiated; and h) The service plan shall include all support services provided or arranged for by the establishment. Based on observation, interview, and record review, the establishment failed to maintain an updated service plan to prevent further falls and injuries for residents with documented history of multiple falls. This deficient practice applies to three of three residents (R1, R2 and R3) reviewed for falls in the sample of three. This failure has the substantial probability to cause harm to residents. The Findings Include: 1. R1's EMR (electronic medical records) showed that she was admitted on June 17, 2025, with multiple diagnoses including Alzheimer's disease, vascular dementia, history of falling, bilateral primary osteoarthritis of hip, unilateral primary osteoarthritis, right knee, pain in right knee,	A4010		

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A4010	Continued From page 2	A4010		

unspecified inflammatory spondylopathy, lumbar region, spinal stenosis, lumbar region, unspecified fracture of right pubis, vitamin B12 deficiency anemia.

R1's fall risk assessment dated June 17, 2025, showed a sore of 21 indicating that R1 is high risk for falls.

R1's MMSE (Mini-Mental State Examination) dated May 20, 2025, showed that R1 had a score of 13 which is severely cognitively impaired. The functional assessment scale dated May 20, 2025, showed that R1 had moderately severe Dementia which was comparable to a 2-3-year-old.

R1's EMR also included additional notes of bed alarm, fall mat hospital bed remind him to lean forward when transferring.

R1's floor assignment details included wheelchair for safety but can walk short distance with walker. Can stand and bear weight but needs supervision for transferring. Tends to lean back when transferring and needs to be cued to lean forward when transferring.

On October 27, 2025, at 12:16 PM, R1 was in the dining room seated on a wheelchair. R1 was noted to have a faint bruise/discoloration on his right side of his forehead. When asked how he got the bruise, R1 stated "I might have fallen by accident and coffered it in the act. I am not certain how I fell. I don't think I have fallen before. I can get out of bed with help."

Facility Incident Report Summary showed that R1 had total five fall incidents on June 18, 2025, June 29, 2025, July 6, 2025, September 27, 2025, October 18, 2025, since admission and

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A4010	Continued From page 3	A4010		

sustained injury during 3 of the 5 fall incidents on June 29, 2025, September 27, 2025, and October 18, 2025.

Incident report dated October 18, 2025, included: Unwitnessed fall, resident observed on floor next to bed, face down. Bruising on right side of resident forehead and right eye, eyeglasses broken. Resident complaining of severe pain from right side of head. Nurse called 911 for transport to ER (Emergency Room), Resident returned to community after x-rays and scans were negative for acute fracture. Conclusion: Resident does not remember he cannot walk without assistance and will randomly stand and walk without waiting for help.

Resident Service care plan updated October 21, 2025, included: Resident to wear gait belt throughout the day. Caregiver is to use bed alarm in wheelchair when resident is alone in his room. Caregivers instructed to keep door open when resident is in his room alone, resident will be evaluated by Psychiatry to address impulsiveness, with POA (Power of Attorney) approval.

On October 27, 2025, at 9:20 AM and 2:06 PM, E2 (Director of Nursing) stated that R1 had had a fall on October 18, 2025, where he sustained an injury of a facial bruise and was sent out to the hospital for evaluation. E2 stated that resident service care plan for R1's fall of October 18, 2025, was done on October 21, 2025. E2 stated that a fall risk assessment was not completed after R1 had the fall with injury on October 18, 2025. E2 stated that she expects a timely update of resident care plan with interventions and that a fall risk assessment must be done during initial assessment and updated annually and/or during

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A4010	Continued From page 4 a change in condition. 2. R2 moved-in at the establishment on March 21, 2025. R2 had multiple diagnoses including, dementia with behavioral disturbance, type 2 diabetes mellitus without complications, vascular parkinsonism, progressive supranuclear ophthalmoplegia and need for assistance with personal care, based on the diagnosis list. On October 27, 2025 at 12:11 PM, R2 was lying in bed, awake, verbally responsive but confused. R2 does not remember any fall incident at the facility. E3 (LPN (Licensed Practical Nurse) was present during the above observation. E3 stated that R2 is confused with history of multiple falls in the room and bathroom. According to E3, due to R2's confusion and poor safety awareness, the resident at times would get up and ambulate without staff assistance and then fall. R2's MMSE (Mini-Mental State Examination) dated March 17, 2025 showed a score of "12" which meant that the resident is severely cognitively impaired. R2's fast scale (functional assessment staging) dated March 17, 2025 showed that the resident was staged at "6c" which meant that R2 has moderately severe dementia with cognitive age of 4 years old. R2's fall risk assessment dated March 21, 2025 showed that the resident was at risk for fall. Review of R2's incident reports summary from admission through October 26, 2025 showed that the resident had fallen 33 times inside his room or inside his bathroom. R2's documented fall incidents were as follows: On April 19, 21 (occurred twice) and 26, 2025. On May 1, 10, 18	A4010		

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A4010	Continued From page 5	A4010		

and 22 (occurred twice), 2025. On June 13, 24, 27 and 28, 2025. On July 2 and 10, 2025. On August 4, 11, 15, 16, 19 and 25, 2025. On September 5, 6 (occurred twice), 11, 15, 24 (occurred twice), 26 and 28, 2025, an on October 12, 22 and 26, 2025. All of the above documented 33 fall incidents showed no injury was sustained.

R2's service plan dated March 17, 2025 showed that the resident required moderate assistance for safety/falls. It was documented under description of assistance for safety/falls, "Resident is a fall risk due to neurological limitations. Needs supervision. To prevent falls." R2's active significant change service plan created on May 6, 2025 showed that the resident required moderate assistance for safety/falls. The same active service plan under description of assistance for safety/falls showed, "Resident is a fall risk with a lack of safety awareness and unable to remember he needs assistance. Encourage resident to remain in common areas, toilet schedule, use gait belt for transfers. Per POA (Power of Attorney) keep WC (wheelchair) locked and at bedside with fall mat in place during sleeping hours. Grippy socks all the time."

On October 27, 2025 at 2:00 PM, E2 (Director of Nursing) stated that resident is confused and with poor safety awareness. According to E2, most of R2's fall incidents happened inside his room, while transferring without staff assistance from bed to wheelchair or from wheelchair to toilet. E2 stated that upon review of R2's incident reports summary, the resident had a total of 33 unwitnessed fall incidents from admission through October 26, 2025. E2 acknowledged that R2's service plan that addresses the resident's safety and fall was not updated and/or revised

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A4010	Continued From page 6	A4010		

since it was last created on May 6, 2025, even though E2 had a total of 28 more fall incidents after the service plan was last created on May 6, 2025. According to E2 per establishment's policy and procedure, after every fall incident of any resident, which is considered a significant change in condition, the service plan should be updated and/or revised to reflect any new approaches or interventions to prevent further fall incidents.

3. The Electronic Medical Record (EMR) showed that R3 is a 74-year-old resident admitted to the facility on April 4, 2025. R3's diagnoses include, but are not limited to, Alzheimer's disease, anemia, hypothyroidism, hyperlipidemia, adjustment disorder with anxiety, post-polio syndrome, atrial fibrillation, lymphedema, duodenal ulcer, low back pain, and gait and mobility abnormalities.

On October 27, 2025, at 11:30 A.M., R3 was observed in the second-floor dining room eating lunch. She appeared confused during the observation. Later the same day, at 3:00 P.M., R3 was observed sitting in her wheelchair near the nurse's office, conversing with several nursing staff members.

The Fall Risk Assessment (dated April 3, 2025): R3 scored 18, indicating a high risk for falls (a score of 10 or higher represents high risk).

The Mini-Mental State Examination (MMSE) (dated April 1, 2025): R3 scored 17, consistent with severe cognitive impairment.

The Functional Assessment Scale (dated April 1, 2025): indicated R3 was moderately severe dementia, with cognitive functioning comparable

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A4010	Continued From page 7	A4010		

to that of a 4-year-old. R3 also demonstrated an inability to manage the mechanics of toileting independently.

The facility's fall incident log documented eight (8) falls involving R3 between July 25, 2025, and October 25, 2025, as follows:
1. July 27, 2025, at 7:06 P.M. - Found on the floor by the TV area; sustained red discoloration to the left side of the forehead
2. August 19, 2025, at 7:55 P.M. - Fall occurred in resident's room
3. August 25, 2025, at 1:16 P.M. - Fall occurred in the hallway
4. September 4, 2025, at 11:48 A.M. - Fall occurred in the hallway
5. September 26, 2025, at 1:56 P.M. - Fall occurred in another resident's room
6. October 15, 2025, at 10:00 A.M. - Fall occurred in R3's room
7. October 16, 2025, at 12:29 P.M. - Fall occurred in R3's room
8. October 25, 2025, at 7:35 A.M. - Fall occurred in R3's room

On October 27, 2025, at 2:15 P.M., E2 (Director of Nursing) stated that R3 is confused, lacks safety awareness, and remains at high risk for falls. E2 confirmed that R3's service plan was last revised on July 25, 2025, and acknowledged that no revisions were made following the eight subsequent fall incidents between July 25 and October 25, 2025. E2 explained that the service plan was not updated because she had been off work and the designated staff did not complete the revisions in her absence. E2 further confirmed that, per facility protocol, a service plan must be revised promptly following each fall incident to ensure appropriate interventions are implemented.

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A4010	Continued From page 8 The establishment's Service Plan Policy (dated February 16, 2025):" Purpose: To maintain an appropriate plan of care for each resident that addresses all services the resident is receiving. The Director of Nursing or Nurse Supervisor, in collaboration with the resident's Responsible Party Member (RPM), shall develop and agree upon a service plan. The service plan shall be reviewed and revised annually, and following any significant change in condition that results in a change in care. Each plan shall address assistance with activities of daily living, dietary needs, and any special accommodations or services for the resident. The establishment's Fall Policy (dated February 27, 2023) showed: "To ensure resident safety by monitoring and tracking falls, maintaining documentation, performing fall risk assessments, and implementing appropriate precautionary interventions. A resident deemed high risk for falls must have preventive and precautionary interventions included in the service plan. The Director of Nursing shall oversee and update each resident's service plan to include all fall safety interventions as necessary."	A4010		