STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005474	A. BUILDING: _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF BELLEVILLE	150 NORTH 27TH STREET BELLEVILLE, IL 62226

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S 000	Initial Comments Complaint Survey 2042705/IL121818 2042715/IL121830 2043213/IL122358 2043238/IL122388 2045261/IL124523 2047156/IL126659 2047924/IL127497 2048652/IL128289	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 3) 300.610a) 300.1210b) 300.1210d)2) 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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: 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirements Were Not Met As Evidenced By: Based on observation, interview and record review, the facility failed to ensure residents receive treatment to maintain highest practicable physical well-being by assessing/monitoring new fractures/dislocations immobilized by splints/braces for three of three residents (R2, R21, R34) reviewed for treatment of fractures/dislocations in the sample of 56. Findings include:	S9999		

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1. R2's Admission Record, not dated, documents 9/21/17 as R2's initial admission date and lists the following diagnoses: Protein-Calorie Malnutrition, Stiffness of unspecified joint, Muscle Weakness, Alzheimer's disease, Dementia, Dysphasia.

R2's Care Plan, dated 3/27/2020, documents "(R2) has impaired cognitive function r/t (related to) Alzheimer's Dementia. (R2) is at risk for falls r/t increased confusion and decreased mobility. She relies on staff assist with ADL's (Activities of Daily Living) and mobility. At risk for skin complications r/t decrease mobility, incontinent bowel and bladder and confusion. Interventions 10/3/2017 ensure proper body alignment, monitor closely for sensory impairment. Observe and assess regularly."

R2's Minimum Data Sets (MDS), dated 3/9/2020 and 4/17/2020, document R2 is severely cognitively impaired and is rarely/never understood.

R2's Progress Note, dated 4/4/2020 at 1:31 AM, documents "CNA (Certified Nursing Assistant) told this RN (Registered Nurse) 'resident is on the floor,' went to room at 0105 to find resident on floor lying on her back with her head towards the foot of bed. Noted left leg was under roommate's bed. Obvious deformity to left knee/femur. Vital signs stable. Resident unable to verbalize how fall happened. Resident pointing to her knee leading this RN to assume she is in pain. (Ambulance) called for emergency transfer to a local hospital. Notifications made and documented."

R2's Local Hospital left knee X-ray report, dated 4/4/2020, documents R2 had a moderately comminuted (fracture producing multiple bone

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S9999	Continued From page 3 splinters), displaced, angulated, fracture of the distal 5th femoral shaft/metaphysis (long, straight part of the thighbone). R2's Local Hospital Discharge Summary, dated 4/10/20, documents R2's reason for admission was fractured femur. The Summary documented "71 year old female resident of a nursing home with a history of severe dementia and a past history of tibia and fibula fracture sustained a fall in the nursing home and was brought to the emergency room, xray of the left femur showed a fracture of femoral neck and patient has been seen/ evaluated by orthopedic but recommended non operative treatment for the fracture considering patient has severe dementia and inability to ambulate. Patient has gait disorder and is mostly in a wheelchair." R2's Local Hospital Transfer Form (Physician Orders), dated 4/10/2020, documents "Recommend follow up x-ray in 6wks (weeks), bedrest for 6wks, wear knee immobilizer w/daily (with) skin checks for pressure injury. *has distal femur fracture w/o (without) intra-articular extension being treated with closed fracture care." R2's Facility Admission Observation, dated 4/11/2020 at 12:58 AM, documents resident is "unable" to communicate needs. The Observation documents "Skin is cool and dry with dressings to the coccyx, left thigh and right heel. Right heel skin peeling no dressing." R2's Daily Skilled Nurse's Note, dated 4/11/2020 at 3:20 PM, documents "Res. (resident) re-admitted day 1. Res. total care per staff. Hand fed per staff. Appetite fair. Repositioned by staff. Pillows for support. Res. has soft cast to left leg."	S9999		

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R2's Daily Skilled Nurse's Note, dated 4/13/2020 at 1719, documents "Res. total care per staff. Hand fed per staff. Appetite fair. Repositioned by staff. Pillows for support. Res. has soft cast to left leg. no s/s (signs/symptoms) of any distress or pain will continue to monitor."

There is no documentation in R2's medical record including treatment records and daily assessments that the facility was visualizing, assessing/monitoring R2's left leg including daily skin checks from 4/10/20 through 4/20/20.

R2's Progress Note, dated 4/20/2020 at 6:00 PM, documents "During CNA rounds, this nurse was called to resident's room due to concern of small amount of blood on sheets near stabilizer. Resident assessed thoroughly, stabilizer noted to LLE (left lower extremity) intact throughout entire shift. During assessment, blood noted inside stabilizer. Deformity noted with bone protruding from left knee. Resident displayed no s/s (signs/symptoms) of verbal/nonverbal discomfort during assessment. Area cleaned and stabilized. CNA and another nurse remained at bedside while this nurse called EMS (emergency medical service), MD (medical doctor), DON (Director of Nursing), and report to (local) hospital ER (emergency room). State guardian called and voicemail left for on-call to return call to facility. 6:15-EMS present to transport resident to ER."

R2's Metropolitan Hospital Discharge Summary, from 4/20/20 hospitalization, documents "Patient was sent back to (local hospital) on 4/20 when the facility was placing a knee brace on her leg, they noticed bleeding coming from the dressing. She was then transferred to a Metropolitan ED (emergency department), for further evaluation.

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In the ED, xray showed comminuted, displaced, extra-articular distal left femur fracture, low lying left patella suggestive of quadriceps tendon injury, intact proximal left femur. She was seen by the ortho (orthopedic) in ED. She was found to have a 2 cm (centimeter) wound with exposed bone and exudates. Ortho determined operative management was appropriate with left above the knee amputation due to chronic nature of the open wound with already degraded tissues around it and non-ambulatory status with the goal to provide definitive care."

The review of the Facility's Injury of Unknown Origin Investigation, dated 4/20/20, did not provide documentation that the facility was visualizing, assessing/monitoring R2's left leg including daily skin checks from 4/10 through 4/20/20.

On 11/10/2020 at 2:31PM V5 (Registered Nurse/RN) stated, "(R2) was complete care. She was contracted. Not alert or responsive to environment. Not verbal. Not completely able to make needs known. Don't remember her having any bed rails. She needed 1 person assistance in bed. She fell out of the bed. She had an obvious deformity. Bent out at the knee in a way that was abnormal. No complaints of pain. But with her cognition she wouldn't be able to tell you she was in pain."

On 11/12/2020 at 11:00 AM V4 (Wound Nurse) stated, "(R2) was alert to self. She was a feeder and had an ulcer to her feet. COVID+ (positive). No open area or pressure area to her left leg. I did not look under the brace. She didn't have any pressure areas under there. I looked under that brace when she first returned. Didn't have any wounds so I didn't look under there anymore."

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On 11/16/2020 at 11:25 AM V6 (R2's Guardian) stated, "(R2) has died. She had a fall at this facility and never recovered. She developed an infection related to the open wound. I was informed she slid in between the bed. That's all I got. She was frail and required repositioning. Once she was in the hospital and after her surgery, I didn't feel it was safe enough for her to return to this facility, so I had her transferred to another (facility)."

On 11/16/2020 at 12:00 PM V7 (Licensed Practical Nurse/LPN) stated, "Prior to her discharge she was a total care patient. She had a stabilizer to her leg. I had not checked under the brace because there was no order on how frequently to check or remove it. The CNA called me to the room. It was some blood on the sheet. The brace was on. I opened it and saw more blood to the inside of the brace. I could see the bone. She had her bone protruding from her leg. I sent her to the hospital. She didn't show any signs of pain, but her cognition is bad. She has no cognition to display grimacing or pain."

On 11/16/2020 12:15 PM V8 (LPN) stated, "I did take care of her. (R2) was alert to self. She did have the brace on. I didn't check under it. The CNA's wouldn't have moved it because she had a gown on. There would be no reason to remove it."

On 11/17/2020 at 10:27 AM V9 (Orthopedic) stated, "I saw her, and she had fracture to her femur. I chose closed fracture care, nonsurgical treatment, because of her cognition; she doesn't walk, and it would not have maintained or improved her quality of life. The leg was to be looked at for pressure injury at least every day. I would expect the facility to monitor the area for

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S9999	Continued From page 7 problems. Checking for swelling, warmth, pulses, capillary refills and any changes. This would have required the staff to look at the leg under the brace. With her having the brace you have to keep an eye on it for any changes because she can't tell you. With her level of cognition, she would not be able to tell you that the changes are happening. This (open fracture) is not something that happens overnight. It happens over time. There would have been swelling, discoloration to the skin, warm to the touch, opening into the leg. Which is why it is important to monitor. If the facility would have been monitoring the area the infection could have been found earlier and prevented the injury from worsening." On 11/18/2020 at 10:26 AM V10 (Orthopedic Surgeon) stated, "(R2) was nonverbal. She did not communicate. She was cachectic (wasting of the body due to severe chronic illness), extremely thin and contracted when she got here, no padding. This amputation could have been prevented. When a fracture happens, the ends of the bone are sharp. As time goes on the tendons tighten and pull on the bone to help it pull into place. When it does this usually there is enough padding to prevent the pulling through the skin. She has no padding, so it puts her at a higher risk for this injury. My concern was how long had this wound been there. This had not just poked through. This was open for a few days prior to coming to (local hospital). She had an infection. The surrounding tissue had already started to try to heal itself. The surrounding tissue was dead and the bone as well. This injury would have been painful. She is nonverbal and not able to express her pain. If the facility would have been performing at least daily checks and monitoring the leg, this is something that could have been prevented. The amputation is a direct result of not	S9999		

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S9999	Continued From page 8 monitoring the fracture. This would have been caught and things could have happened differently if she was being monitored. We could have gotten her in here and treated her. She would have had surgery, but she still would have her leg." On 11/18/2020 at 11:15 AM V18 (Physical Therapist) stated, "I have cared for (R2) and she had a severe cognitive decline. We (Physical Therapy) evaluated her and because of the bedrest order and her inability to follow commands we did not pick her up. We did the eval and the staff were able to demonstrate putting on the brace properly." On 11/18/20 at 12:55 PM V19 (LPN) stated, "When performing an assessment, that information would be documented in the progress notes or in the daily skilled notes, if they are Med A. If a resident had a fracture, I would assess on my shift any redness or swelling. The assessment documentation would go in the daily skilled note or the progress note. It would be one of these two places if it was done." On 11/18/20 at 1:00 PM V16 (LPN) stated, "We document our assessments in the daily skilled or the progress notes. What I do is, I document in the daily skilled first and if anything else happens during my shift, I would then document in the progress notes." On 11/18/20 at 1:09 PM V17 (LPN) stated, "All of the assessments are either in daily skilled notes or if there is a specific assessment, that is in the computers under forms. This is where it would be completed under the forms tab. If needed, we can document in the progress notes but mostly it would be under that (forms) tab."	S9999		

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S9999	Continued From page 9 On 11/30/2020 at 1:03 PM V3 (Assistant Director of Nursing) stated, "If a resident has an immobilizer, we check it depending upon the doctor's orders. Each nurse would look at the leg every shift and document it on the MAR or TAR. I am aware of the open area with the bone protruding. I don't know how that happened. There should be a place on the TAR that has check immobilizer and the nurse would document each shift at least. I would expect them (the nurses) to look under the brace and assess. Looking at the skin color and or any changes. If they were looking at the leg at least every shift, they would have found it and any other changes immediately. She did not return to the facility, so there was nothing put in place; there was nothing done. If she would have returned, then we would have put something in place." On 11/18/20 and 11/30/20 R2's Daily skilled notes, progress notes, Medication Administration Records, Treatment Records and Forms Tab were reviewed. There is no documentation in R2's medical record including treatment records and daily assessments that the facility was visualizing, assessing/monitoring R2's left leg including daily skin checks. The Facility's Splints/Devices Policy, dated 12/2/2020, documents Guideline: 3. Devices will be removed each shift and prn (as needed) to assess the resident's skin and circulation under the device. 2. R21's Admission Record/Face Sheet documented diagnosis of Fracture of the lower end of left radius (shorter of the two long bones in the forearm).	S9999		

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R21's Care Plan, dated initiated 10/01/20, documents "(R21) requires the use of splint to r/t (related to) left wrist fracture and instability. Applies herself. Staff to provide assist for care and hygiene." The Care Plan Interventions, initiated on 12/1/20, documents "Encourage resident to assist with applying and removing brace. Encourage resident to demonstrate ability to apply the brace and praise participation with program and improvements. Observe skin for complications r/t brace usage every shift and each time it is removed. Provide proper cleaning of brace on resident's specific shower days and PRN (when needed) when soiled. Provide verbal cues as to proper placement of brace when applying." R21's Care Plan Problem, dated 11/27/20, documented readmitted from hospital with Fx (fracture) left Radius, left hip hematoma." The Care Plan Intervention, dated 12/11/2020, documents "To wear left wrist splint @ all times, off for hygiene."

R21's MDS, dated 12/4/2020, documents R21 is cognitively intact.

R21's TAR (Treatment Administration Record), dated December 2020, documents "Left wrist splint, off for care, skin check Q (every) shift. Every day and night shift." On 12/5/20, 12/10/20, and 12/11/20 R21's TAR documents no skin check for day shift.

On 12/14/2020 at 10:30 AM R21 stated, "I put my brace on myself. It only comes off when I take a shower. I take showers twice a week. V4 (Wound Nurse) comes in and looks at my leg but not my wrist. The nurses don't look at it at all."

3. R34's Care Plan, dated 12/1/20220, documents "SPLINT: (R34) requires the use of

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S9999	Continued From page 11 splint to r/t left knee instability secondary to TKA (Total Knee Arthroplasty) posterior dislocation." The Care Plan Intervention, dated 12/1/20, documented "Encourage resident to assist with applying and removing brace. Encourage resident to demonstrate ability to apply the brace and praise participation with program and improvements. Observe skin for complications r/t brace usage every shift and each time it is removed. Provide proper cleaning of brace on resident's specific shower days and PRN when soiled. Provide verbal cues as to proper placement of brace when applying." The Care Plan Intervention dated 12/1/20, documents "Splint to be on when up, off while in bed." R34's MDS, dated 9/29/2020, documents R34 is cognitively intact. R34 TAR, dated December 2020, documents, "WBAT (weight bearing as tolerated) with left knee brace on at all times when up (may remove when in bed). Skin check Q (every) shift. Every day and night shift." R34's TAR documents no skin checks for the following dates during the day shift: 12/4, 12/5, 12/6, 12/7, 12/8, 12/9, 12/10, and 12/11/20. On 12/14/2020 at 9:40 AM R34 stated, "I put my brace on myself. I do put in on wrong sometimes. No one helps me. They do not look under my brace every shift. They don't look under it at all." (A) (Violation 2 of 3)	S9999		

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S9999	Continued From page 12 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 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. 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:	S9999		

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S9999	Continued From page 13 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirements Were Not Met As Evidenced By: Based on observation, interview and record review, the facility failed to assess residents for fall risk, provide supervision, progressive	S9999		

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S9999	Continued From page 14 interventions, ensure fall interventions were implemented, complete fall investigation, and determine a root cause analysis of fall to prevent falls for 8 of 9 residents (R2, R3, R4, R11, R14, R16, R17, R21) reviewed for accidents and supervision in the sample of 56. These failures resulted in R2 sustaining fracture to her femur; R3 sustaining a fracture to right hip, right pelvis and right femur; R21 sustaining a large painful hematoma to her left hip area requiring hospitalization; R11 having multiple falls in which he sustained a left hip fracture requiring surgical repair on one fall, a right hip fracture requiring surgical repair with another fall, and a laceration requiring 6 sutures on another fall; R14 sustaining a nasal fracture; R16 sustaining a fractured tooth; and R4 sustaining a 3 centimeter laceration to her head. Findings include: 1. R2's Care Plan, dated 3/27/2020, documents, "(R2) is at risk for falls r/t (related to) increased confusion and decreased mobility. She relies on staff assist with ADL's (Activities of Daily Living) and mobility. At risk for skin complications r/t decreased mobility, incontinent of bowel and bladder, and confusion." R2's Care Plan does not document a new intervention based on root cause analysis for R2's fall on 4/4/2020. R2's Minimum Data Set (MDS), dated 3/9/2020, documents R2 as totally dependent of 2 person physical assist for bed mobility. R2's Fall Risk Assessment, dated 3/9/2020, documents high risk for falls.	S9999		

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S9999	Continued From page 15 R2's Nurses Notes, dated 4/4/2020 1:31 AM, document, "Note Text: CNA (Certified Nursing Assistant) told this RN (Registered Nurse) 'resident is on the floor,' went to room at (1:05 AM) to find resident on floor lying on her back with her head towards the foot of bed. Noted left leg was under roommate's bed. Obvious deformity to left knee/femur. Vital signs stable. Resident unable to verbalize how fall happened. Resident pointing to her knee leading this RN to assume she is in pain. {Company name} called for emergency transfer to local hospital. Notifications made and documented." R2's Electronic Health Record does not document a fall assessment for 4/4/2020 fall. R2's Local Hospital left knee X-ray report, dated 4/4/2020, documents R2 had a moderately comminuted (fracture producing multiple bone splinters), displaced, angulated, fracture of the distal 5th femoral shaft/metaphysis (long, straight part of the thighbone). R2's Local Hospital Summary, documents R2's reason for admission was fractured femur. The Summary documented, "71 year old female resident of a nursing home with a history of severe dementia and a past history of tibia and fibula fracture sustained a fall in the nursing home and was brought to the emergency room, X-ray of the left femur showed a fracture of femoral neck and patient has been seen evaluated by orthopedic but recommended non operative treatment for the fracture considering patient has severe dementia and inability to ambulate. Patient has gait disorder and is mostly in a wheelchair." R2's Local Hospital Transfer Form (Physician	S9999		

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S9999	Continued From page 16 Orders), dated 4/10/2020, documents "Recommend follow up x-ray in 6 wks (weeks), bedrest for 6 wks, wear knee immobilizer w/daily (with) skin checks for pressure injury. *has distal femur fracture w/o (without) intra-articular extension being treated with closed fracture care." R2's Fall Investigation Report, dated 4/4/2020, documents at 12:55 AM CNA reported resident was on the floor. Entered room Resident on back next to bed on floor with her head pointing towards the foot of the bed. Left leg under bed of roommate with obvious deformity to left femur/knee. Resident unable to give description. Immediate Action Taken: Gave pillow and blanket to resident and left on floor until EMS (emergency medical service) arrives. Called for emergency transport by (ambulance service); VSS (vital signs stable). Oriented to person. Predisposing Physiological Factors: Confused, Incontinent, Noncompliant with safety Guidance, Impaired Memory. 4/8/2020 Notes: IDT (interdisciplinary team) reviewed incident, investigation, and finding, documents in part "RCA (Root Cause Analysis): According to cna while performing rounds found (R2) on floor by her bed with deformity noted to left leg. (R2) sent to ER (emergency room) for further eval (R2) sustained fx (fracture) to left femur with no surgical interventions, remains in hospital at this time. All prior interventions were in place and appropriate time of fall. Based on investigation no abuse or neglect identified." R2's Fall Investigation Report does not document an effective or complete root cause analysis of fall and/or intervention put in place. On 11/10/2020 at 2:31 PM, V5 (Registered Nurse/RN) stated, "She (R2) was complete care.	S9999		

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S9999	Continued From page 17 She was contracted. Not alert or responsive to environment. Not verbal. Not completely able to make needs known. Don't remember her having any bed rails. She needed 1-person assistance in bed. She fell out of the bed. She had an obvious deformity. Bent out at the knee in a way that was abnormal. No complaints of pain. But with her cognition she wouldn't be able to tell you she was in pain. I'm not sure how she fell. She didn't move in the bed. It was a freak thing. I'm not sure how she fell." On 11/19/2020 at 9:17 AM V26 (Certified Nursing Assistant/CNA) stated, "I worked with her (R2) before she fell. She was moved to a different hall after she fell. Before her fall she was a total care. Complete care. She didn't move. Once she was in the bed, she was just there. You had to move her. She didn't turn herself or move around in the bed. I don't know how she fell because she didn't move. It didn't make sense." On 11/19/2020 at 11:53 AM V27 (CNA) stated, "She (R2) was total care. She had an air mattress. She didn't move at all. I found her on the floor. I believe it was her air mattress that caused her fall. Her mattress kept malfunctioning. It would deflate from time to time. I don't remember if it was deflated at the time because I was focused on her on the floor. I know that before the fall the mattress was messing up." On 11/30/20 at 1:03 PM, when asked about R2's falls, V3 (Assistant Director of Nursing/ADON) stated, "Which time? I do remember one night, (V20) called me and told me she had found (R2) on the floor. I don't know how she fell. She was turned different. Her head was at the foot of the bed and her legs were at the top of the other bed. She didn't move in the bed. Wasn't very mobile at	S9999		

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all. She didn't try to transfer self or nothing like that. I'm not sure how she fell. I was not in the building when she fell. I do believe she was one of the residents that had problems with her mattress. We have had air mattresses that have malfunctioned and deflated, but I don't remember if that was the issue."

On 1/3/2020 at 3:23 PM, per phone interview, V54 (Physician) stated, "When I saw her she was up in her chair. If her mattress was malfunctioning, the ideal solution would be to replace it."

2. R3's Care Plan, dated 3/20/20, documents, "FALL: (R3) is at high risk for falls r/t weakness, recent hospitalization, and cognitive delay. Provide frequent visual checks on (R3) to ensure safety. Provide proper, well maintained footwear. (R3) is at risk for complications r/t incontinence secondary to cognitive delay. He requires frequent reminders to use the rest room and supervision to ensure that he is performing appropriately."

R3's MDS, dated 2/7/2020, documents, "Severely impaired cognitively. Short and long-term memory problems. BIMS (Brief Interview for Mental Status) should not be performed because resident is rarely/never understood. Requires supervision with one person physical assist for transfers."

R3's Incident Investigation Report, dated 3/26/2020, documents, "Resident in therapy bathroom on toilet. Resident had fallen in bathroom and had a skin tear to Left elbow. No other skin issues noted. When asked how resident fell, resident stated he fell on his butt because the floor was wet. Resident then stated

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he fell on his legs. Resident aware of wet floor sign stating, 'they mopped it.' When asked why he came in this bathroom if the floor was wet, he stated he had to poop. When asked why he didn't use his room bathroom, he stated he didn't want to."

R3's Nurses Notes Note, dated 3/27/2020 at 2:21 AM, documents, "Text: X-ray results obtained. Resident has sustained fracture to right hip, right pelvis and right femur. Physician notified. New order received to send to emergency room. Call placed to resident's sister. No answer received. Voice message left instructing to call facility to speak with the nurse. Administrator notified. Call placed to EMS. Report called to local hospital. Resident resting quietly in bed at this time with eyes closed. Monitoring ongoing."

R3's Nurses Notes, dated 3/27/2020 at 2:57 AM, documents, "Note Text: Resident is leaving facility at this time transferred via EMS in route to local hospital. Transferred to stretcher via 2 person assist. Tolerated well. No s/s (signs/symptoms) of distress during transfer. Unable to reach family to notify of transfer. Will continue to attempt to reach family. Bed hold notification sent with resident."

The facility provided a timeline, signed and dated 11/10/2020 by V1 (Administrator) which documents, in part, "He (R3) approximately functions similar to a 4 to 5 year old."

On 11/12/2020 at 11:30 AM, V1 stated, "Residents returning from hospital are placed on the COVID hall and placed on isolation. There is one nurse and two CNA's to make sure the residents are cared for and supervised."

On 11/30/2020 at 1:03 PM, V3 (ADON) stated,

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S9999	Continued From page 20 "(R3) was challenging. He was on the COVID hall because of recent hospitalization. He had behaviors and difficult to redirect. He required supervision. Sometimes even one on one supervision. The staff would try to redirect. Sometimes it worked and sometimes it wouldn't. He needed a lot of supervision and staff interaction. When he fell in the bathroom, he was alone. Staff were not with him." On 11/18/2020 at 12:30 PM, V46 (R3's guardian) stated, "I was told that he fell on a wet floor. They said that there was a wet floor sign, but he went into the bathroom anyway. (R3) can't read, so the sign wouldn't have done anything for him anyway. It wouldn't have stopped him. He couldn't read it." 3. R17's Care Plan, dated 9/23/2020 documents, "FALL: (R17) is at risk for falls r/t history of Falls and poor balance. She has been noted to get up from her chair and attempt to sit on the floor. She requires redirection at times. Often restless at night, redirected to nurses' station when awake. Resident is an extensive assistance of two staff members for ADLs. Resident has incontinence present. Wheelchair used." "4/16/20 During night shift rounds, when restless, up and out with staff until breakfast, offer snack." R17's MDS, dated 9/30/2020, documents, "Frequently incontinent and requires extensive physical assist from two plus persons." R17's Incident Report Investigation, dated 6/9/2020 3:50 AM, documents, "resident was found on the floor at the 300/400 hall nurses' station by the cna." R17's Incident Report Investigation, dated 6/26/2020 0:315, documents, "CNA notified this	S9999		

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S9999	Continued From page 21 nurse that resident was sitting on floor next to 300/400/500 hall nursing station." On 12/8/2020 at 1:30 PM, V24 (Restorative Nurse) stated, "I did investigate (R17's) falls. She got up out of her chair. She gets up which is why she has to sit at the nurses' station when she is up at night as well. With her sitting at the nurses' station, it is the hope that she would be watched by the staff. With both of these falls, staff were not at the nurses' station where she was. They were down the hall providing care for another resident. When returned, they found her on the floor. This happened with both falls." On 12/23/2020 at 12:58 PM, V2 (Director of Nursing/DON) stated, "Placing the resident at the nurses' station helps with supervision. If she was sitting at the nurses' station, I would expect (R17) to be supervised." 4. R21's Care Plan, dated 9/16/2019, documents, "FALL: (R21) is at high risk for falls r/t (related to) functional deficits, non-compliance, poor balance;" "9/14/20 x-rays result, no findings;" "10/5/20 X-ray to left hip. Resident unrealistic about long term goal to return home unassisted, requires reeducation of need for assist and encouragement to use call light. Poor safety recall, believes therapy can strengthen her to go home;" "11/16/20 Increased seizure activity, N.O. (new order) for med change;" "11/22/20 Labs result - N.N.O. (no new order), CXR (chest X-ray) resulted no findings;" "11/27/20 Readmitted increased weakness, requires more assist, seizure medication changes made during hospitalization;" "12/1/20 Labs in house resulted, seizure meds adjusted;" "10/5/2020 Bedside commode;" "11/1/2020 Encourage to use bedside commode during night hours or use call light to	S9999		

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S9999	Continued From page 22 ambulate to restroom." R21's MDS, dated 9/16/2020, documents cognitively intact and extensive assist of one person physical assist for transfers. R21's Electronic Health Record documents R21 having 12 falls from July 7, 2020 to December 13, 2020. The November 15, 2020 fall resulted in a diagnosis of Hematoma. R21 was hospitalized for hematoma to left hip area with severe pain. R21's Incident Report, dated 7/7/2020 3:46 PM, documents in part, "res (resident) found on floor next to bed in room. RCA Poor balance, noncompliance." R21's Incident Report, dated 9/12/2020 9:30 PM, documents in part, "Resident asked what happened; resident replies 'I was trying to pick up my bag off the floor and lost my balance.' Resident c/o (complained of) left ankle pain and bilateral hip pain. RCA: Poor balance, noncompliance." R21's Incident Report, dated 10/5/2020 8:30 AM, documents in part, "Resident was ambulating to her bed in her room and fell onto the floor. No witness found. Resident stated she had pain in her L (left) ankle and L wrist. RCA: Poor balance, noncompliance." R21's Incident Report, dated 10/5/2020 1:30 PM, documents in part, "Resident was found on floor in the bathroom doorway. Injury type: Hematoma to face. Resident transported to hospital for evaluation. RCA Poor balance, noncompliance." R21's Incident Report, dated 11/1/2020 4:00 AM, documents in part, "Resident was ambulating in	S9999		

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S9999	Continued From page 23 room to bathroom and fell on floor. No witness found. RCA Poor balance, weakness, noncompliance." R21's Incident Report, dated 11/15/2020 1:10 AM, documents in part, "Heard crash from room. Went to find resident laying on her left side with her head resting on the floor. Resident has hematoma on left hip, however there is no internal or external rotation of the hip. CMST (circulation, movement, sensation, temperature) to right lower extremity wnl (within normal limits). No witness found. RCA weakness, noncompliance." R21's Incident Report, dated 11/16/2020 5:12 AM, documents in part, "Resident roommate came to tell Nurse that res (resident) is on the floor. Went to room to find resident lying on her left side with her head resting on the floor. No injuries, only complaining of dizziness and pain level at 4. 'I was trying to get on my commode and fell.' RCA: Seizure." R21's Incident Report, dated 11/22/2020 12:56 PM, documents in part, "Nurse was in hallway passing meds when res roommate came in hallway and stated that resident was on the floor. Nurse went into room and saw res sitting in buttocks on floor next to roommate's bed. Res stated she was trying to go to the restroom at this time, lost her balance and her legs gave out. T99.1 Tylenol given to lower temp. RCA: increased weakness." R21's Incident Report, dated 11/23/2020 7:55 PM, documents in part, "This nurse called to resident's room. Resident observed lying on floor next to bed on her back. Resident stated she fell. Injury type: fracture suspected/ruled out left	S9999		

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trochanter (hip). Sent to hospital for evaluation. No witness found. RCA: seizure, increased weakness."

R21's Discharge Summary, dated 11/27/2020, documents in part, "Reason for admission: hematoma, seizures. Patient developed hematoma of the left hip area associated with pain which happened when patient fell at the nursing home. X-ray did not show any evidence of fracture but patient has large hematoma of the left hip area which is causing severe pain."

R21's Nurses Notes, dated 11/28/2020 7:21 AM, documents, "Note Text: RN came onto hall and was called to resident room. Resident stated she was taking herself to the toilet and slid out of her chair landing on her buttock. Resident was seated on floor with her feet in bathroom doorway facing into bathroom. Resident c/o discomfort in left hip. A large hematoma was present from previous fall and a lidocaine patch was present. No deformation noted. Resident lifted into w/c (wheelchair). Resident stated she hit her head on w/c. no laceration or hematoma noted to head."

R21's Incident Report, dated 11/28/2020 7:21 AM, documents, "Resident Description: resident stated she was taking herself to the toilet and slid out of her chair landing on her buttocks. No witness found. RCA: Increased weakness and medication change per neuro during hospital stay."

R21's Nurses Notes, dated 11/29/2020 2:32 PM, documents, "Nurses Notes Note Text: Resident found in seated position on floor near bathroom with feet near bathroom and back towards doorway entering room. Resident denies pain or discomfort. No deformities noted. Resident

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BRIA OF BELLEVILLE	150 NORTH 27TH STREET BELLEVILLE, IL 62226

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S9999	Continued From page 25 returned to wc." R21's Incident Report, dated 11/29/2020 2:32 PM, documents in part, "Resident Description: resident stated she was taking herself to the toilet and slid out of her chair landing on her buttocks. RCA: Increased weakness and medication change per neuro during hospital stay. " On 12/9/2020 at 2:53 PM, R21 observed in her room. No bedside commode was present in room. On 12/9/2020 at 2:50 PM when asked about her falls, R21 stated, "I fall a lot. I'm not sure why. I just keep falling. This last time, I used the call light and waited. Just like they said. It took forever. So I took myself. My wheelchair - it's broke. It rolled back when I tried to stand up. I went right onto the floor. I told (maintenance). They ain't did nothing about it yet." When asked if R21's bedside commode was in place, would she have used it. Resident stated "Yes." R21's Incident Report, dated 12/13/2020 11:54, documents in part "Res roommate came to nurses' station to inform nurse that res fell to the floor. Res was sitting on the floor by the bedside. Res stated she was trying to use the commode and slipped and fell. RCA: Weakness and unassisted transfer/ambulation. On 12/14/2020 at 10:30 AM, V30 (Nursing Assistant) assisted R21 with toileting. V30 applied the brakes to the wheels on R21's wheelchair. V30 then assisted R21 into the standing position. R21 pushed up, using arm rest from the wheelchair. The wheelchair right wheel rolled backwards. R21 began waving back and forth. R21 grabbed a hold of the wall. V30 then assisted	S9999		

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R21 onto the toilet. R21 pointed to the wheelchair. V30 checked the wheelchair and verified the wheelchair brakes were on. V30 was able to roll the wheelchair, forwards and backwards, with the brakes on.

On 12/14/2020 at 9:37 AM, V24 (Licensed Practical Nurse/LPN/Restorative Nurse) stated, "(R21) has had a lot of falls. Her falls are because she doesn't listen and gets up. I am not aware of a wheelchair being involved in her falls. I am not aware of her wheelchair not working properly and have not checked the wheelchair."

On 12/14/2020 at 10:35 AM, R21 stated, "That damn wheelchair is raggedy. The brakes don't work. It don't work. I told them."

On 12/14/2020 at 10:40 AM, V30 stated, "The brake is broken. It doesn't lock in place."

On 12/14/2020 at 11:30 AM, V31 (Maintenance Director) stated, "If a resident has a fall and equipment is involved, the IDT (Interdisciplinary Team) tells me and I look at it and fix it if needed. I am not aware of (R21's) wheelchair not working properly. I have not worked on the wheelchair."

On 12/16/2020 at 11:09 AM, V2 stated, "If the resident slid out of the wheelchair, I would expect the wheelchair to be looked at as to why. If the resident says the wheelchair is broken, I would expect maintenance to look at the wheelchair and repair or replace it. Interventions that are put in place are expected to follow the resident with room move."

On 1/3/2020 at 3:23 PM, V54 (Physician) stated, "She has had a stroke with right sided paralysis, her balance is poor, and she attempts to walk.

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S9999	Continued From page 27 Trying to do things on her own. It is not uncommon that she would have these falls. They (facility) need to make it clear to her to make sure she calls for help. The facility has to make it clear to her. Of course, you would want to increase supervision. They could try frequent checks but with two CNAs to 20 to 30 people, that's not practical." 5. R11's Admission Record, print date 12/8/2020, documents R11 was admitted on 7/20/2017 and has diagnoses of Displaced Fracture of base of neck left femur onset date 10/4/2020, Diabetes Mellitus onset date of 7/20/2017, difficulty walking onset date of 8/29/20, Displaced intertrochanteric fracture of right femur, onset date of 8/29/20, Dementia onset date of 7/20/2017, and Bipolar Disorder onset date of 3/16/2018. R11's MDS dated 3/19/2020, documents R11 is severely cognitively impaired, requires supervision of 1 staff member for locomotion, and uses no mobility devices. R11's Fall Report, dated 3/30/2020, documents, "Nursing Description: this nurse was informed that resident fell out on the patio while another resident stated that he lost his balance but did not hit his head. Resident Description: resident stated he lost his balance and fell while on the patio when he went out to smoke. Immediate Action Taken: resident assisted into a w/c to use. Injury Type: No injuries observed at time of incident." This Fall Report does not document new interventions or a Root Cause Analysis of the fall. R11's Fall Report, dated 5/29/2020 at 6:23 PM, documents, "Nursing Description: Staff came to get nurse states resident fell in hallway and hit his head. Resident did not have wheelchair and	S9999		

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tripped over scale and hit head on grab bars. Resident Description: Resident stated he fell out of wheelchair but did not have his wheelchair. Immediate Action Taken: Resident was immediately assessed for any fractures. Gauze applied to head gash and arm lacerations. Injuries Observed at Time of Incident: Injury type: Laceration. Injury Location: 15) Right antecubital. Injury type: Laceration. Injury Location: Face. Mental Status: Confused/Forgetful. Oriented to Person. Predisposing Physiological Factors: Confused, Gait imbalance, impaired memory and Weakness/Fainted. Notes: IDT review and investigation: Alert with confusion. Non-compliant with wheelchair use poor balance and BLE (bilateral lower extremity) weakness. Often ambulates without assist. Room located across hall from scale, walked out unassisted before staff could approach and tripped over scale and lost balance. Interventions: Halls clear and free of clutter, staff reeducated on monitoring ambulation in halls unassisted, encourage use (of) wheelchair." This fall report does not document the RCA of the fall.

R11's Nurses Noted, dated 5/29/2020 at 4:21 PM, documents, "Note Text: Resident fell in hallway while activities was taking residents to go on smoke break. Resident tripped over scale in hallway and hit his head on metal grab bars. Resident had a head gash, lacerations to right arm and elbow. Sent to local hospital for evaluation and treatment."

R11's Emergency Room Visit report, dated 5/29/2020, documents, "Review of Systems: Skin: Dry, warm, laceration 3 cm (centimeters) diagonal above right eye, other (superficial abrasions on right knee, superficial square shaped skin tear measuring 3 cm by 3 cm and

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S9999	Continued From page 29 located proximal to right elbow without significant bleeding). ED (Emergency Department) Procedures: Wound/Laceration Repair #1 wound location: above left eye. wound length (cm): 3. Skin sutures: 6." R11's Nurses Note, dated 5/30/2020, documents, "Note Text: Late Entry 5/29/2020; resident discharged from Hospital. 7:04 PM resident returns to facility transported by ambulance via stretcher accompanied by 2 attendants; readmitted to assigned room (#). Upon returning resident has absorbable stitches to center forehead, bruising/swelling to right /left eye bruising and laceration to right arm." R11's Nurses Note, dated 6/2/2020, documents, "Late Entry: Note Text: res noted to have 6 sutures to forehead from recent fall and 2 skin tears to right elbow and right upper arm. no pain noted." R11's MDS, dated 6/19/2020, documents R11 is severely cognitively impaired, requires limited assistance of one staff member for walking in the corridor, supervision of one staff member for locomotion, R11 uses a wheelchair for locomotion and during walking is not steady, only able to stabilize with staff assistance. R11's Fall Report, dated 8/7/2020 at 5:24 PM, documents, "Nursing Description: res was found on the floor in activities area. Resident Description: I was helping (another) put his shoe on, lost my balance and fell. Immediate Action Taken: Resident assisted back to w/c with assist of 2. Injuries Observed at Time of Incident: Injury Type: Skin Tear Injury Location 17) Right elbow. Mobility: Noncompliant with Ambulation Guidance. Mental Status: Oriented to Person,	S9999		

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S9999	Continued From page 30 Orientated to Place. Predisposing Physiological Factors: Noncompliant with Safety Guidance, impaired memory. Notes: dated 8/10/2020, IDT review and investigation: Alert with confusion. Non-compliant with wheelchair use poor balance and BLE weakness. Often ambulates without assist. Leaning forward in wheelchair to help peer with shoes, poor balance and posture, fell forward. RCA: Weakness and manageable dehydration for poor fluid intake and insistence to go out to smoke. Seen in ER 8/4/2020, encourage fluids. Interventions: Tilted w/c seat to assist in positioning." R11's Fall Report, dated 8/23/2020 at 5:28 PM, documents, "Nursing Description: CNA came and told nurse that res fell to the floor trying to go to the restroom. Resident Description: res stated he was trying to go to the restroom and he had fell to the floor. Immediate Action Taken: VS (vital signs) are stable at this time, nurse assisted res to bed, res has a skin tear to r (right) elbow which was treated with TAO (triple antibiotic ointment) and d/d (dry dressing), res now has a floor mat in place, res was instructed on how to use call light and ask for help. Mental Status: Confused/Forgetful. Notes, dated 8/25/2020, IDT Review and investigation: Alert with confusion. Non-compliant with wheelchair use poor balance and BLE weakness. Often ambulates without assist. Ambulating to restroom unassisted, poor balance and posture. RCA: Toileting unassisted. Interventions: Sent to ER to eval (evaluate) and treat, toileting program, bed in lowest position." R11's Nurses Note, dated 8/23/2020 at 5:33 PM, documents, "res fell to the floor trying to go to restroom, res has skin tear to r elbow which was treated with tao and d/d, res also c. o. (complaint of) pain in right hip, X-ray has been ordered at	S9999		

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S9999	Continued From page 31 this time, vs (vital signs) are stable, neuro (neurological) checks in place, no signs of distress noted, res has Tylenol given for pain, no signs of distress or discomfort noted at this time." R11's Nurses note, dated 8/24/2020 at 6:05 AM, documents, "Right hip X-ray reported r/t fall, writer rec'd (received) orders to send to ER for further eval/tx (evaluation and treatment). Resident admitted with dx (diagnosis) of right hip fx (fracture)." R11's Hospital Progress Note, dated 8/28/2020, documents, "Patient admitted with hip fracture, status post cephalomedullary nailing of right hip fracture." R11's Hospital Patient Transfer Form, signed 8/28/2020, documents, "Hospital Admitting Diagnosis: hip fracture. Activity: up with assist and walker. Ambulatory Status: Assist of 2 required with walker." R11's Nurses Note, dated 8/31/2020, documents, "Note Text: re-admission skin assessment completed. res noted to have 3 incisions to right hip from surgery. incisions are well approximated with 18 staples noted. dry drsg (dressing) ordered to area daily. no pain noted. scab noted to left lower arm and scattered bruising to bilateral lower arms. res was pleasantly confused with assessment; does not remember having surgery to hip. will cont (continue) to monitor." R11's Fall Report, dated 9/3/2020 at 8:25 PM, documents, "Nursing Description: Found res on his back on the floor in his room. Resident Description: "I took a header." Injury type: Abrasion. Injury Location: Left scapula. Injury type: Skin tear. Injury Location: Right hand.	S9999		

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S9999	Continued From page 32 Mental Status: Confused/Forgetful, Oriented to person, not oriented. Predisposing Physiological Factors: Noncompliant with Safety Guidance, Gait imbalance, Recent illness. Notes, dated 9/4/2020, IDT Review and investigation: Alert with confusion. Non-compliant with transfer need for assist, BLE weakness new right hip fracture and repair. Ambulating unassisted, poor balance and posture. RCA: Poor memory and decreased safety awareness. Interventions: In view of staff when restless." R11's Fall Report, dated 9/4/2020 at 6:00 PM, documents, "Nursing Description: Writer was coming out of room (#) and heard resident yelling 'Help me, help me, help me.' Writer entered room to observed resident laying on the floor next to bed 1, legs stretched out in front of him stating 'Help me up.' Resident stated he was trying to get in bed 1 when his bed is bed 2, unassisted. Resident Description: Resident stated he was trying to get in bed. Immediate Action Taken: Head to toe assessment completed. Resident was noted with +ROM x 4 (positive range of motion for all 4 extremities) and noted with skin tears on his forearms from previous fall the night before. No abnormal deformity or rotation of extremities noted. Resident stated he was sore all over but refused Tylenol denying new pain. Resident was alert but confused. Resident was assisted off the floor after head to toe assessment performed and transferred back to his chair. Resident was placed in his wheelchair, face mask applied and was placed in the hallway outside of his room door for closer observation. (V54, Medical Doctor) called and informed of incident. No new orders received at this time in assessment. VS WNL (within normal limit) and resident attempted to finish his dinner but only ate a few bites. Staff also initiated q (every) 1 hr	S9999		

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rounding on him and allowed him to self propel his wheelchair in hallway due to restlessness and frequently redirected when he attempted to leave unit. Injury Type: No injuries observed at this time. Mental Status: Confused/forgetful, Oriented to person and Oriented to situation. Predisposing Physiological Factors: Incontinent, Noncompliant with Safety Guidance, Gait imbalance, Impaired memory, recent illness and weakness/fainted. Predisposing Situation Factors: Improper footwear, ambulating without assist and during transfer. Notes, dated 9/9/2020, IDT Review and investigation: Alert with confusion. Non-compliant with transfer need for assist, BLE weakness new right hip fracture and repair. Ambulating unassisted, poor balance and posture. RCA: Poor memory and decreased safety awareness. Interventions: In site of staff from dinner to bedtime."

R11's Nurses Note, dated 9/4/2020, documents, "Note Text: Writer was coming out of room (#) and heard resident yelling 'Help me, help me, help, me.' Writer entered room to observe resident laying on the floor next to bed 1, legs stretched out in front of him stating 'Help me up.' Resident stated he was trying to get in bed 1 when his bed is bed 2, unassisted. Resident was noted with +ROM x 4 and noted with skin tears on his forearms from previous fall the night before. No abnormal deformity or rotation of extremities noted. Resident stated he was sore all over but refused Tylenol denying new pain. Resident was alert but confused. Resident was assisted off the floor after head to toe assessment performed and transferred back to his chair. Resident was placed in his wheelchair, face mask applied and was placed in the hallway outside of his room door for closer observation. (V54) called and informed of incident. No new orders received at

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this time in assessment. VS WNL and resident attempted to finish his dinner but only ate a few bites. Staff also initiated q 1 hr rounding on him and allowed him to self propel his wheelchair in hallway due to restlessness and frequently redirected when he attempted to leave unit. Attempted to call family but received voicemail."

R11's MDS, dated 9/5/2020, documents R11 is severely cognitively impaired, requires extensive assist of 1 staff member for transfer, limited assistance of two staff members for walking in the room and corridor, extensive assist of 2 staff members for locomotion, R11 uses a walker and a wheelchair for locomotion and during transfer and walking is not steady only able to stabilize with staff assistance. This MDS also documents R11 has a range of motion impairment on 1 side in the lower extremities and has an indwelling urinary catheter.

R11's Fall Report, dated 9/11/2020 at 3:07 PM, documents, "Nursing Description: this nurse was notified by 2 staff that this res fell back while sitting in his wheelchair, this event happened in the 100 hall dining room. Resident Description: I was trying to get up and smoke. Immediate Action Taken: res was assessed, vital signs were taken, this res is c/o mild pain in his lumbar region. res was assisted back in wheelchair, no open area noted. This nurse got an order for an X-ray of this res back and right hip/femur. no other complaints at this time. Mental Status: Confused/forgetful, Oriented to person, Oriented to place and Oriented to situation. Predisposing Physiological Factors: Incontinent, Noncompliant with Safety Guidance, Impaired memory and Other. Notes, dated 9/14/2020, IDT Review and investigation: Alert with confusion. Non-compliant with transfer need for assist, BLE weakness, new right hip

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S9999	Continued From page 35 fracture and repair. Standing unassisted, expecting a smoke break, after time left unattended while restless, poor balance and posture. RCA: Poor memory, decreased safety awareness, desire to smoke. Interventions: Staff reeducation, X-ray to right hip." R11's Fall Report, dated 9/12/2020 at 1:00 PM, documents, "Nursing Description: CNA entered room to collect resident lunch tray, resident found in a seated position with his back towards his bed. resident denies pain or discomfort, no bruising, bleeding or deformities noted. Resident returned to bed. Resident Description: resident states he was trying to get up to the bathroom after eating. Immediate Action Taken: education provided to prevent further falls including using call light, waiting for assistance, how to safely transfer. Mental Status: Oriented to person, Oriented to place, Oriented to time and Oriented to situation. Predisposing Physiological Factors: Gait imbalance, weakness/fainted. Notes, dated 9/14/2020, IDT Review and investigation: Alert with confusion. Non-compliant with transfer need for assist, BLE weakness new right hip fracture and repair. Ambulating unassisted, poor balance and posture. Attempting to toilet self, unaware of indwelling urinary catheter placement. No BM (bowel movement) noted. RCA: Poor memory, decreased safety awareness. Interventions: Up in wheelchair for meals." R11's Nurses Notes, dated 9/25/2020, documents, "Note Text: res has arrived back to facility at this time, res is in stable condition at this time, res will cont (continue) physical therapy wbat (weight bearing as tolerated)." R11's Fall Report, dated 9/29/2020 at 10:30 AM, documents, "Nursing Description: this nurse was	S9999		

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notified by staff that this res fell out of his w/c in the hallway and onto the floor. Resident Description: 'I was trying to get up and go pee.' Immediate Action Taken: res was quickly assessed, vitals were taken, MD was called. res was then placed back in w/c with 2 staff assist. MD ordered stat left hip X-ray. res was explained that he has a indwelling urinary catheter and placed in front of the nurses' station to be observed and in view at all times. Injury Type: Abrasion. Injury Location: Left elbow. Mental Status: Confused/Forgetful, Oriented to person. Predisposing Physiological Factors: Confused, incontinent and Impaired memory. Notes, dated 9/29/2020, IDT Review and investigation: Alert with confusion. Non-compliant with transfer need for assist, BLE weakness new right hip fracture and repair. Ambulating unassisted, poor balance and posture. Attempting to toilet self, unaware of indwelling urinary catheter placement, tripped over catheter. RCA: Impaired cognition, ambulating unassisted. Interventions: Indwelling urinary catheter bag at all times."

R11's Nurses Note, dated 9/29/2020, documents, Note Text: "res X-ray results came back, res has a subtle hairline subcapital fx of the left femoral neck. MD notified of X-ray results. res is being sent to hospital. daughter was called and notified. will cont to update as more information becomes available."

R11's Nurses Note, dated 9/29/2020, documents, "Note Text: this nurse called for a update on resident; resident was admitted to hospital with a hip fracture."

R11's Radiology Report, dated 9/29/2020, documents, "Findings: There is a left subcapital hip fracture with mild displacement."

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BRIA OF BELLEVILLE	150 NORTH 27TH STREET BELLEVILLE, IL 62226

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S9999	Continued From page 37 R11's Nurses Note, dated 10/4/2020, documents, "Note Text: Resident returned to facility and taken to room (#) and placed in bed by ambulance personnel and RN. resident is alert oriented to self and facility. denies pain sob (shortness of breath) or other needs at this time. indwelling urinary catheter intact and draining clear yellow urine to gravity. left hip has staples present covered with island dressing." R11's Hospital Patient Transfer Form, signed 10/4/2020, documents that R11 was admitted on 9/29/2020 with a hip fracture, had a Left hip bipolar hemiarthroplasty (surgical procedure that replaces one half of the hip joint with a prosthetic, while leaving the other half intact) on 10/1/2020. Activity Posterior hip precautions. Ambulatory Status: Assist of 2 required with walker. R11's MDS, dated 10/11/2020, documents R11 has modified independence for cognitive skills in decision making. This MDS also documents R11 requires extensive assist of 2 staff members for transfer and bed mobility, walking did not happen, extensive assist of 1 staff member for locomotion, R11 uses a wheelchair for locomotion and during moving from seated to standing position is not steady and is only able to stabilize with staff assistance. This MDS also documents R11 has a range of motion impairment on both sides of the lower extremities. R11's Fall Report, dated 10/22/2020 at 9:40 PM, documents, "Nursing Description: Called to resident's room by another staff member who stated that resident was on the floor. Entered room to find resident on the floor next to his wheelchair lying on his back with his knees bent. Resident Description: 'I don't know what	S9999		

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S9999	Continued From page 38 happened, get me off this floor.' Immediate Action Taken: Assessment negative for injury however resident started to c/o left hip/femur pain so an x-ray was ordered. Injury Type: No injuries at time of incident. Mental Status: Confused/Forgetful, Oriented to person. Predisposing Physiological Factors: Confused, Noncompliant with Safety Guidance, Gait imbalance and Impaired memory. Predisposing Situation Factors: Recent Room Change and Ambulating without Assist Notes, dated 10/23/2020, IDT Review and investigation: Alert with confusion. Non-compliant with transfer need for assist, BLE weakness, new right hip fracture and repair. Ambulating unassisted, poor balance and posture. Left brake not properly locking. RCA: Impaired cognition, self transfer. Interventions: Wheelchair maintenance and repair, floor mat." R11's Fall Report, dated 11/3/2020 at 7:02 PM, documents, "Nursing Description: nurse went into res room and saw res lying on floor mat, res stated he was trying to get up, no bruising or bleeding noted at this time. Resident Description: res stated he was trying to get out of bed and lost his balance. Immediate Action Taken: nurse and aides assisted res off floor, skin assessment completed, no new injuries noted, vs stable at this time. Injury Type: No injuries observed at this time. Mental Status: Confused/Forgetful, Oriented to person. Predisposing Physiological Factors: Confused. Predisposing Situation Factors: Ambulating without Assist. Notes, dated 11/6/2020, IDT Review and investigation: Alert with confusion. Non-compliant with transfer need for assist, BLE weakness new right hip fracture and repair. in bed by request. RCA: Poor trunk control with bed mobility. Intervention: winged mattress."	S9999		

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S9999	Continued From page 39 R11's Fall Report, dated 11/14/2020 at 11:10 AM, documents, "Nursing Description: resident toileted and placed in bed by CNA. CNA placed wheelchair in bathroom. 30 minutes later a resident yelled out that resident was on the floor. Writer entered room. Resident was laying on his back in front of the sink with w/c at his side. Resident c/o sore buttocks, but denies hitting his head. Full ROM X 4 extremities, no abnormal deformities or abnormal rotations of hip/legs. Resident assisted back to wheelchair x 2 assist. Resident would not state what he was trying to do exactly. Resident Description: Resident would not state what he was trying to do exactly. Resident stated he got up because he is stubborn and he can do what he wants to do. Immediate Action Taken: Head to toe assessment, resident brought to nursing station for closer observation by staff. Injury Type: No injuries observed at this time of incident. Mental Status: Confused/Forgetful, Oriented to person, Oriented to Place, Orientated to Situation. Predisposing Physiological Factors: Confused, Incontinent, Noncompliant with Safety Guidance, Gait imbalance, Impaired memory and Weakness/Fainted. Predisposing Situation Factors: Improper footwear and Ambulating without Assist. Notes, dated 11/17/2020, IDT Review and investigation: Alert with confusion. Non-compliant with transfer need for assist, BLE weakness new right hip fracture and repair. in bed by request, increased confusion and decreased endurance. RCA: Weakness and confusion. Intervention: Keep up in wheelchair after toileting during day hours when awake." R11's Fall Report, dated 11/14/2020 at 12: 23 PM, documents, "Nursing Description: Resident observed on the floor by CNA, 10 minutes prior, CNA placed resident in room and set up his tray for lunch, left room and resident got out of	S9999		

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wheelchair, attempted to stand unassisted and fell forward towards roommates chair, witness states resident broke his fall by landing near roommates leg. Resident scraped right lateral eyebrow on side of roommate's wheelchair. Scant amount of bleeding noted to scratch on right lateral eye. Resident c/o right elbow pain, assessed area, bruising noted with various stages of healing. Does not appear fresh. But c/o soreness. MD made aware of 2nd fall. MD gave orders to X-ray bilateral elbows. (V63, R11's PO/ power of attorney) phoned and informed of both falls. (V63) was able to speak with R11 and decided she will purchase some paints and miscellaneous activities to keep resident busy. (V63) states that he may be bored and looking for something to do. Resident currently sitting at nurses' station with writer. Resident was also provided non-skid socks to prevent sliding when resident attempts to stand and self transfer. Resident Description: Resident offers no reason for why he attempted to stand unassisted other than him stating 'I told you I was stubborn' and smirked. Injury Observed at time of Incident: Injury Type: Bruise. Injury location: Right elbow. Injury Type: Skin tear. Injury location: Left elbow. Mental Status: Oriented to person, Oriented to situation. Predisposing Physiological Factors: Confused, Incontinent, Noncompliant with safety Guidance, Gait imbalance and Weakness/Fainted. Predisposing Situation Factors: Improper footwear, ambulating without assist and during transfer. Notes, dated 11/17/2020, IDT Review and investigation: Alert with confusion. Non-compliant with transfer need for assist, BLE weakness new right hip fracture and repair. in bed by request, increased confusion and decreased endurance. Poor mood. RCA: Weakness and confusion. Intervention: Staff encourage to get up and in dining room for

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meals, redirect from negative statements."

R11's Fall Risk Evaluations, dated 3/30/20 - 11/3/2020, all document R11 is a high fall risk.

On 12/23/2020 at 4:00 PM, V2 (DON) stated, "Maybe (R11) needed more supervision, but he was a hard one. He would tell you that he was an old man and he was going to get up."

On 11/17/2020 at 2;30 PM, V53 (LPN) stated, "(R11) is very confused now. We would have to keep him up at the nurses' station as much as possible. Before he declined in mobility, he would be independent. Both of his hip fractures, he told me he was trying to go to the bathroom. We would have to babysit him."

On 12/9/2020 at 12:30 PM, V20 (RN) stated, "(R11) is very demented, very pleasant and he has no safety awareness. I would keep him with me when he was awake. He was close to the nurses' station so I could hear him if he was up in his room. I had that luxury at night."

On 1/4/2021 at 1:15 PM, V2 stated, "A resident that requires an indwelling urinary catheter should have a leg bag on during the day."

6. R14's Admission Record, print date of 11/18/2020, documents R11 was admitted on 12/11/2012 and has diagnoses of Dysphagia, Cerebral Infarction and Hemiplegia and Hemiparesis following Cerebral Infarct and Dementia with behavioral disturbances.

R14's MDS, dated 2/11/20, documents R14 has a cognitive skill for decision making of moderately impaired, requires extensive assist of 2 staff members for bed mobility and transfer, and has

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S9999	Continued From page 42 range of motion limitations on both sides of her upper and lower extremities. R14's Care Plan, dated 12/14/2012, documents, "Focus: Fall: (R14) is at risk for falls r/t staff assist with transfers, weakness, and diagnosis of CVA (cerebral vascular event) with left sided weakness. (R14) has been noted to refuse to lay down between meals. She is at risk for bleeding and bruising r/t anti-coagulation therapy. 4/29/20 Sent to ER, x-ray done no findings. 5/9/20 Sent to ER for eval, X-ray done, resulted in nasal fracture. Son requested D/C (discontinuation) of therapy. 5/12/20 Sent to ER for eval, UA (urinalysis) collected at hospital. 5/13/20 Son consent to evaluation only from therapy to evaluate positioning and wheelchair appropriation." R14's Nurses Note, dated 4/29/2020, documents, "Note Text: This nurse was notified by the CNA that the resident was in room on the floor. this nurse found the resident on the floor in a supine position. the cna stated the resident was trying to get clothes out of drawer and fell to floor. resident noted to have a quarter size hematoma to right side of head. ice pack applied. resident denied having any pain. resident assisted back to bed with mechanical lift. MD notified with new order to send resident to hospital for evaluation due to order of xarelto. emt arrived with two assist. resident assisted on stretcher to hospital." R14's Fall investigation report, dated 4/29/20, documents, "Incident Description: Nursing Description: This nurse notified by CNA that the resident was in the floor in their room." This Fall investigation fails to document that an investigation was completed with an RCA or new interventions put into place to prevent future falls.	S9999		

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S9999	Continued From page 43 R14's Occupational Therapy (OT) Evaluation and Plan of Treatment, Start of Care date: 5/6/2020, documents, Short Term goals: #2 Patient will increase sitting balance during ADLs (Activity of Daily Living) to Fair + of the time to right self reduce the risk for falls and facilitate upright posture. Current Referral: Reason for Referral: patient is a 80 year old female resident of this facility that has been referred to skilled therapy due to decline in strength, balance, and coordination, impacting safety and independence with ADL performance." R14's Nurses Note, dated 5/9/2020, documents, "Note Text: Res. was in therapy department. (Staff) from therapy came out and said that res. was on floor. Stated that she had left her for only a few minutes to throw away water from helping her to brush her teeth. Res. found on right side of body. Has raised area over right eyebrow. Noted blood on floor. No laceration. Blood from nose and mouth. Noted cut on right side of upper lip. Applied ice glove to right eye brow. Ambulance service called. Will send Ambulance due to no vehicles available. Report called to local ER. Res. transferred to stretcher per assist. V/S 97.6-18-103/76-60." R14's Hospital Visit Information, dated 5/9/20, documents, "You were seen today for: Traumatic hematoma for forehead, Nasal Fracture and Lip Laceration." R14's Computed tomography (CT) Scan, dated 5/9/2020, documents, "Impression: Partially imaged right nasal bone fracture is new when compared to the previous CT scan of April 29, 2020.	S9999		

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S9999	Continued From page 44 R14's Nurses Note from 5/9/2020, documents, "Note Text: Res. returned from ER. Transferred by Ambulance from stretcher to bed per 2 assist. Noted res. had one stitch in right upper lip. Raised area over right eyebrow decreased in size. Res. seen by (V54 Physician) on arrival. Son no longer wants res. to receive physical therapy." R14's Fall investigation report, dated 5/9/20, documents, "Incident Description: Nursing Description: Called to therapy by therapist. Stated that she was assisting res with brushing her teeth and left her sitting for a few minutes to throw away water. Returned to find res on floor on right side. Res had fallen from mat to floor. Notes, dated 5/11/2020, IDT review and investigation: Sitting up to perform oral hygiene with staff, left out of visual for a moment, leaned forward, poor BUE/BLE (bilateral upper extremity/bilateral lower extremity) strength to aid in preventing fall. Interventions: Not to be left unattended when sitting upright in wheelchair for care." R14 was actually sitting on the therapy mat/table at time of fall. On 12/9/2020 at 10:07 AM, V64 (Certified Occupational Therapy Assistant/COTA) stated, "She (R14) was on a bed table sitting up, her balance was fine. I left her to get some water and when I got back, she was on the floor. She had a cut on her lip. I got the nurse for her to come and assess her." R14's Nurses Note, dated 5/12/2020, documents, "Note Text: This nurse was notified by the CNA that resident was on the floor in the dining room laying in supine position. the CNA stated that the resident was leaning over and 3 x she attempted to lay resident back and tell her to be still while she was pushing her out of the dining room. The	S9999		

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S9999	Continued From page 45 CNA witnessed the resident going down and confirmed the resident went head first and hit her head. resident had laceration to forehead that was cleaned with dry dressing applied. pain on 3 of number scale of 10. spoke with son poa (power of attorney) to notify of resident condition and transfer to hospital. will update as more information becomes available." R14's Nurses Note, dated 5/13/2020, documents, in part, "Note Text: ER nurse called this nurse and gave report that no new fractures or injuries with res recent fall. res is resting at this time. no pain noted. VS WNL. bandage to forehead. no bleeding noted. will cont to monitor." R14's Fall Report, dated 5/12/2020, documents, "Nursing Description: This nurse was notified by CNA that the resident was on the floor in the dining room." This Fall Report fails to document that an investigation was completed, no RCA or new interventions put into place to prevent future falls. On 12/9/2020 at 9:50 AM, V16 (CNA) stated, "(V65, CNA) was pushing her (R14) in the wheelchair. (R14) kept leaning forward. (V65) would tell her to sit back and (R14) just leaned forward and fell to the floor. (R14) got a hematoma and stitches in the ER, I think. I expected (V65) to get help so we could assist to keep (R14) from leaning and to assess her as to why she is leaning. After these falls, (R14) has just deteriorated. I think this is just her new baseline. She has been sent out for CT Scans to ensure she hasn't had another stroke and it was negative." On 12/24/2020 at 4:00 PM, V2 stated, "(R14) should not have been left on a table alone during	S9999		

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a therapy session. I would expect the aide to stop pushing (R14) in her chair if she continues to lean forward and get help to assist."

7. R16's Admission Record, print date of 11/18/2020, documents that R16 was admitted on 6/12/2020 and has diagnoses of Dementia and Adult Failure to Thrive.

R16's MDS, dated 6/19/2020, documents R16 is severely cognitively impaired and requires extensive assist of 2 staff members for bed mobility and transfers.

R16's Care Plan, dated 8/5/2020, documents, in part, "Focus: Fall: Resident is at high risk for falls r/t decreased mobility and stiffness. Will sit self up on side of bed unassisted when staff is not present. Interventions: 9/29/20 Bolster overlay. 8/5/2020 Fall Risk assessment quarterly and as needed. Falling Star Program. Keep bed in lowest position. Rounding at a minimum of q 2 hours and prompt assist for change in position, toileting, offer fluids, and ensure resident is warm and dry."

R16's Nurses Note, dated 8/28/2020, documents, "Note Text: This nurse called to resident's room. Resident observed lying on the floor next to her bed. No sign of trauma noted. No bruising, contusions, skin tears, extremities moved with passive ROM and no expressions of pain. Resident assisted back to bed. Vitals of (temperature) 98.1 (blood pressure) 130/68 (pulse) 82 (respirations)18 98@ O2 sat (oxygen saturation) Room Air. Will follow fall protocols. No injury noted at this time. Call light operative and within reach."

R16's Fall Report, dated 8/29/20 at 3:00 AM, documents, "Nursing Description: This nurse

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S9999	Continued From page 47 called to Resident's room. Resident observed lying on the floor next to bed. Mental Status: Oriented to Person. Predisposing Physiological Factors: Confused. Predisposing Situation Factors: Improper footwear, Other information: Muscle stiffness, can sit up unassisted. Notes, dated 8/31/2020, IDT review and investigation: Alert to self, poor bed mobility, overall joint stiffness but able to sit up unassisted when staff is not around. RCA: Poor trunk control and barefoot. Interventions: Floor mats, gripper socks at all times." R16's Nurses Note, dated 9/30/2020 at 1:55 AM, documents, in part, "Note Text: Nurse was notified by the CNA that the resident was on the floor in room. The nurse found the resident laying on the floor towards the head of the bed. there was blood coming from the mouth of the resident, no other injuries noted. Resident was assisted back to bed. Res was sent to hospital for further examination. Will call hospital for update." R16's Nurses Note, dated 9/30/2020, documents, "Note Text: Res came back from hospital @ 2:45 AM Dx acute dental trauma, cut on upper and lower lips. No new order for medication. Res is resting in bed, will continue to monitor." R16's Emergency Room Visit Report, dated 9/29/2020, documents, "HEENT (Head, Eyes, Ears, Nose and Throat): There is blood on her lips. There is a mucosal laceration midline about 1 cm on her upper lip and two on her lower lip, same size. One is on the right side and the other is midline - both mucosal. There is blood on her upper gum as well. I was unable to move any of her teeth. She does have a broken tooth on the left side of her upper tooth number 10."	S9999		

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S9999	Continued From page 48 R16's Fall Report, dated 9/29/20 at 8:40 PM, documents, "Nursing Description: CNA heard from another res that her roommate was on the floor in his room and yelled for nurse to come. When this nurse walked in the room the resident was laying on the floor by side of her bed, with blood coming from resident mouth. Notes, dated 9/30/2020, IDT review and investigation: Alert to self, nonverbal, decreased mobility and stiffness throughout all joints. Will sit self up on side of bed unassisted when staff is not present. Interventions: Bolster Overlay." No RCA done during this investigation. On 12/24/2020 at 4:00 PM, V2 stated, "Maybe (R16) needed more supervision." On 12/9/2020 at 1:55 PM, V25 (LPN) stated, "(R16) did fall one night. I think she slid out of bed and when she did, she hit her mouth on the furniture and hurt her mouth. I couldn't tell were the blood was coming from; that's why I sent her out." On 12/9/2020 at 10:52 AM, V22 (LPN) stated, "(R16) is alert and oriented x 1, she is contracted and she can sit up in bed. I don't know what happened. I found her on the floor. The aides should be doing rounds every 2 hours at night." On 12/9/2020 at 11:50 AM, V17 (LPN) stated, "(R16) squirms in bed but she is unable to sit herself up in bed." On 12/9/2020 at 12:30 PM, V20 (RN) stated, "(R16) is a wiggler. She is unable to sit herself up in bed." On 1/3/2021 at 7:00 AM, V75 (CNA) stated that R16 is unable to sit up in bed by herself.	S9999		

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S9999	Continued From page 49 On 1/3/2021 at 3:00 PM, V54 (Physician) stated, "(R11) had Dementia. He would always want to go out and smoke, putting him at risk for osteoporosis. He would fall and break his bones. His falls are unavoidable because of his dementia. Someone like that is hard to keep an eye on them, hard to watch them all the time. He is demented and wants to get up. (R16) has dementia; she tries to get up. It is so hard to keep an eye on them. No, (R16) can't get up in bed by herself. It is unacceptable for therapy to leave (R14) alone in therapy. The CNA should have protected (R14) from falling out of the wheelchair; she has dementia she doesn't know what she is doing." 8. R4's Face Sheet documents she was admitted to the facility on 6/15/20 with the diagnoses of Type 2 Diabetes Mellitus, Cognitive Communication Deficit, Muscle Weakness, Difficulty in Walking, Schizophrenia, and Alzheimer's Disease. R4's MDS dated 6/22/20 documents she is severely impaired cognitively and requires extensive assist with bed mobility, transfers, ambulation, dressing, and toileting. The same MDS documents R4 had two or more falls since she was admitted. R4 had actually had 3 documented falls since she was admitted one week prior to the assessment. R4's Care Plan identifies the focus: Fall: (R4) is at risk for falls; history of falls, cognitive deficit and weakness secondary to diagnosis of Schizophrenia, with the date initiated: 12/8/20. Her care plan focus: "Fall" did not identify that she had actual falls on 6/16/20, 6/17/20 or 6/27/20.	S9999		

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S9999	Continued From page 50 R4's Fall Report, dated 6/16/20 at 12:55 AM, documents she was found lying face down on the floor next to the bed, with no injuries found at the time of the incident. No predisposing environmental or physiological factors were identified for R4's fall, but it was identified that she was admitted within the last 72 hours. R4's Interdisciplinary Team (IDT) review and investigation identified the interventions as 15 minute checks x 24 hours, bed in lowest position, and sent to ER (Emergency Room) to rule out injury, not admitted, returned same day, no injuries. The root cause of this fall by R4 was determined to be: resident in new environment and has poor safety awareness and confusion. R4's hospital records, dated 6/16/20 at 2:07 AM, documented R4 "presents to the ED (Emergency Department) from the facility after a fall at 8:00 PM." The hospital records include documentation that on 6/16/20 at 4:21 AM, "(V20, RN), from the facility called to check the status of R4 and advised that R4's bed does not have side rails and this is what likely caused her to fall from bed." R4's Fall Report, dated 6/17/20 at 8:30 PM, documented she had a second fall at that time in her room. On 6/19/20 the IDT review and investigation identified the root cause of R4's fall as poor cognition and safety awareness along with decreased mobility and strength. New interventions for this fall were to move R4 to a room closer to the nurses' station and bilateral assistive side rails. R4's Side Rail Review form dated 6/17/20 at 4:26 PM had recommended, "The resident will utilize side rails that are not considered a restraint and will be utilized to enable the resident to attain and maintain her practicable level." Although R4's assessment	S9999		

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S9999	Continued From page 51 identified the need for side rails on 6/17/20, they were not in place that evening when she fell, and instead were an intervention put in place after she fell again that evening. R4's Fall Report, dated 6/27/20 at 12:50 PM, documented R4 was observed flat on her stomach on the floor in her room and she was complaining of left arm pain, she had a scratch below her left elbow and also an open injury sustained to her left eyebrow. She was transferred by ambulance to the emergency room. The fall report documented the root cause of this fall to be "due to the resident being incontinent at the time of the incident it is believed she was getting up to use the restroom or was restless from already being incontinent." Interventions included: sent to ER, door opened, hourly rounds." R4's hospital records, dated 6/27/20, document, "ED general exam: Head: Evidence of Trauma-3 centimeter (cm) laceration over the left temporal area with surrounding dried blood and no active bleeding; Eyes: erythema to left upper and lower eye lids without swelling; Extremities: Limited range of motion (ROM) left upper extremity due to pain; tenderness left shoulder; linear abrasion left forearm 12 cm long." Treatment included wound adhesive to laceration left temporal head. X-rays of left shoulder and left hip, and CT of head and C-spine were negative for fracture." On 12/23/20 at 4:00 PM, V2 stated that she agrees that the fall investigations should be completed thoroughly and confusion is not a root cause analysis and fall interventions should be put into place to prevent falls. The Facility's Fall Prevention and Management	S9999		

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S9999	Continued From page 52 Policy, dated 10/28/2020, documents, "General: This facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed and the resident's existing plan of care shall be evaluated and modified as needed." It continues under Facility Guideline following a fall incident "3. A fall risk evaluation is completed by the nurse. A score of 10 or greater indicates the resident is at "high risk" for falls; a score of less than 10 indicates "at risk" for fall. 4. Care Plan to be updated with a new intervention based on root cause analysis after each all occurrence." (A) (Violation 3 of 3) 300.610a) 300.1210b) 300.1210d)2) 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	S9999		

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S9999	Continued From page 53 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. 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: 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirements Were Not Met As Evidenced By: Based on observation, interview and record review, the facility failed to cleanse and monitor a Gastrostomy tube (G-tube) site, follow physician	S9999		

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S9999	Continued From page 54 orders, check for placement using auscultation and residual checks, and turn off the tube feeding when the head of the bed is lowered to the flat position for 4 of 5 residents (R6, R14, R16, R20) reviewed for G-tubes in the sample of 56. This failure resulted in R6 requiring hospitalization for diagnosis of an infected G-tube site requiring antibiotics and antifungals. Findings include: 1. R6's Face Sheet documents she was first admitted to the facility on 6/18/20 with diagnoses of Anxiety Disorder, Chronic Obstructive Pulmonary Disease, and Chronic Pancreatitis. R6's Hospital Records dated 6/25/20 to 7/17/20 document that she had a gastrostomy tube (g-tube) inserted on 6/30/20 for diagnosis of severe malnutrition. R6 was readmitted to the facility on 7/24/20. Per progress notes, R6 was admitted to the hospital on 8/23/20 with diagnosis of Heart Failure. R6 did not return to the facility. R6's hospital records dated 8/22/20 documents she was seen in the emergency room on 8/22/20 at 9:50 PM and subsequently admitted with the diagnoses of g-tube site infection, cellulitis of lower extremities, aortic regurgitation with fluid overload and adult neglect. These hospital records included physical exam findings of R6's abdomen: diffusely tender to palpation, worse around g-tube site; g-tube site with erythema and purulent discharge. According to these hospital records, the pus from the g-tube site was cultured and the History and Physical report dated 8/27/20 identified the results of that culture as growing moderate mixed microorganisms including a few	S9999		

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S9999	Continued From page 55 Pseudomonas aeruginosa, which was treated with 7 day course of antibiotic and antifungal treatment. The same hospital History and Physical report also included the diagnosis of Adult Neglect related to staff having been previously dismissive of g-tube site infection. R6's Order Summary Report dated 12/8/20 includes documentation of orders, dated 7/28/20 to auscultate g-tube for placement, flush her g-tube before and after medication administration, and to check residual through g-tube every shift. The Order Summary Report also included the order dated 7/28/20 for weekly skin checks on Wednesdays on night shift. R6's Order Summary Report did not include any orders for assessment or treatment to her g-tube site. R6's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated July 2020 and August 2020 do not document any orders for treatment and assessment of g-tube site until August 23, 2020, which was the day after R6 was sent to the hospital and she did not return to the facility. R6's TARs dated July 2020 and August 2020 document skin checks were performed on 7/17/20, 7/22/20, 7/29/20, 8/6/20, 8/12/20, and 8/19/20, but there was no documentation of assessment and/or treatment of R6's g-tube site. R6's TAR dated August 2020 included the order, "Cleanse stoma site daily with soap and water during routine care. May be done by nursing assistant if no open areas, every night shift for g-tube site." The start date for this order was 8/23/20, the day after R6 was sent to the emergency room and admitted for g-tube site infection. There were no other orders related to treatment of R6's g-tube site noted in her	S9999		

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S9999	Continued From page 56 electronic medical record. R6's CNA (Certified Nursing Assistant) Skin Attention Form dated 8/22/20 but untimed, documents, "No skin problems noted." R6's Care Plan, initiated 6/22/20 documents, "(R6) is at risk for complications with weight and nutrition related to pancreatitis, chronic hyponatremia, Chronic Obstructive Pulmonary Disease (COPD), severe underweight status, malnutrition, PEG-J (g-tube) status, poor intake, c-diff (bacterial infection), and history of not tolerating greater that 30 milliliters/hour of tube feeding formula. Another Care Plan focus, dated 7/20/20, was, "Tube Feeding: (R6) is at risk for complications related to PEG-J (g-tube) need, intolerance to formula or rate, possible infection to enteral site, underweight status, and chronic pancreatitis." There were no interventions for either of these Care Plan focuses to monitor the g-tube for signs and symptoms of infection, or plan for treatment and assessment of R6's g-tube site. On 12/21/20 at 12:40 PM, V2 (Director of Nursing/DON) stated she did not know why or when R6 was sent to the hospital on 8/23/20. She stated she thought it might have been early in the morning on 8/23/20, but she was not sure if there were problems with her g-tube site or not. V2 stated the nurse should have filled out a transfer form detailing her assessment and reason for sending R6 to the hospital and would have included the date and time of the transfer. V2 stated that documentation was not done, and that nurse has since resigned from the facility. On 1/3/21 at 3:00 PM, V54 (Physician) stated, "Normally a G-Tube site will have drainage	S9999		

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S9999	Continued From page 57 around it. The nurses are not going to see redness or puss unless they manipulate the G-tube. If the G-tube was placed right, there should not have been a problem since this was a new G-tube. I do expect the nurse to chart if there is a problem and notify me." 2. R16's Admission Record, print date of 11/18/2020, documents R16 was admitted on 6/12/2020 with a diagnosis of Gastrostomy status. R16's MAR, dated November 2020, documents, "Enteral Feed Order every day and night shift Enteral Feeding Formula Jevity 1.5 Rate 50 CC (cubic centimeters)/hr (Hour). Order date 6/12/2020." R16's November 2020 Physician Order documents, "Enteral Feed Order every day and night shift Enteral Feeding Formula Jevity 1.5. Rate 50 cc/hr. Order date 6/12/2020." R16's Dietary Note, date 10/13/2020, documents, in part, "TF (tube feed) Jevity 1.5 at 50 ml (milliliters)/hr plus 200 ml water q (every) 6 hours via gastrostomy tube (G-tube)." On 11/9/2020 at 11:15 AM, R16 was observed lying in bed with Jevity 1.5 running at 65 ml/hr via G-Tube. During care provide by V32 (Certified Nurse Assistant/CNA) and V33 (Nurse Assistant/NA), the G -tube site had a dark brown crusty residue around the stoma site extending approximately 3/4th of an inch. The stoma site had no dressing around it. The CNAs put the head of the bed all the way down while performing incontinence care for R16 with the tube feeding still running.	S9999		

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S9999	Continued From page 58 On 11/9/2020 at 3:15 PM, V17 (Licensed Practical Nurse/LPN) stated, "I wash the G-tube site at least once a shift." V17 then confirmed R16's Jevity 1.5 was running at 65 ml/hr. 3. R20's Admission Record, print date of 11/18/2020, documents R20 was admitted on 5/4/2015 with diagnosis of Dysphagia following cerebral infarction. R20's Care Plan, dated 1/6/2020, documents, "Focus; Tube Feeding: (R20) is at risk for complications r/t (related to) new g- tube placement. She receives Osmolite 1.2 with a 100 ml water flush per MD (Medical Doctor) orders. Interventions: Check feeding tube residual as ordered. Keep HOB (head of bed) raised to 30 degrees. Tube feeding as ordered." R20's Order Summary, dated November 2020, documents, "Check placement of G-tube using auscultation before administering food/medications/fluids." On 11/9/2020 at 11:58 AM, V16 (LPN) administered a 100 ml water flush via the G-tube. V16 failed to verify placement by auscultation. V16 exposed the G-tube stoma which had a buildup of crusty brown debris. On 11/9/2020 at 11:58 AM, V16 stated, "I usually clean my G-tube sites at the end of my shift." 4. R14's Admission Record, dated 11/18/2020, documents R14 was admitted 12/11/2012 with diagnoses of Dysphagia following unspecified Cerebrovascular Disease and Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side.	S9999		

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S9999	Continued From page 59 R14's Order Summary, dated November 2020, documents, "Check placement of G-tube using auscultation before administering food/medications/fluids." On 11/9/2020 at 12:00 PM, V14 (LPN) administered a 150 ml water flush via the G-tube. V16 failed to verify placement by auscultation. On 12/15/2020 at 3:00 PM, V2 stated, "I would expect the nursing staff to clean around the G-tube site if it is dirty. I expect the nurses to check G-tube placement by auscultation and checking for residual before administering anything through the G-tube. I expect the nurses to turn off the tube feeding if the resident's bed is going to be laid flat for care." The facility's Gastrostomy/Jejunostomy Tube Care and Maintenance policy and procedure, review date 9/2017, documents, "Daily care of the gastrostomy/Jejunostomy tube and exit site will extend the life of the tube, prevent peristomal skin irritation, and assure appropriate hygiene of the tube exit site." The policy guidelines include, "4. Clean the tube site daily with mild soap and water, rinse (unless no rinse soap is used) and dry. 5. Observe the peristomal skin for redness, irritation or gastric leakage." (B)	S9999		