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S 000	Initial Comments Investigation of Facility Reported Incident of: 6-16-21/IL135393 6-30-21/IL135547 6-27-21/IL135689 Complaint Investigation 2165188/IL136260	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 3) 300.610a) 300.1210b) 300.1220b)3) 300.3240a) 300.3240f) 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		

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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.

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)

f) Resident as perpetrator of abuse. When an

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investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

These requirements were not met as evidenced by:

Facility failures resulted in two deficient practice statements.

A. Based on observation, interview, and record review the facility failed to recognize repetitious resident to resident sexual activity as nonconsensual sexual abuse, failed to ensure residents were not subjected to sexual abuse by another resident, and failed to evaluate or assess residents' capacity or ability to consent to sexual activity given their diminished cognition related to Dementia. These failures affect six residents (R2, R8, R12, R15, R17, R19) of 27 residents reviewed for sexual abuse in the sample of 33 residents. These failures have the potential to affect all 23 residents (R2, R4, R5, R7, R8, R10, R12, R13, R14, R15, R16, R17, R18, R19, R21, R22, R23, R24, R25, R26, R27, R30, R31) who reside on the dementia care unit.

B. Based on record review and interview, the facility failed to prevent physical abuse of residents by other residents. This failure affects three (R3, R4, R10) of ten residents reviewed for physical abuse in the sample of thirty-three.

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S9999	Continued From page 3 Findings include: A.1. R15's Admission Record dated 7/19/21 documents R15 has a diagnosis of Dementia with Behavioral Disturbances. R15's Minimum Data Set (MDS) dated 4/7/21 does not document the section for cognition and decision making was completed. This MDS documents R15 ambulates with supervision from staff. R15's MDS dated 1/5/21 documents R15 has a BIMS (Brief Interview for Mental Status) score of 7, indicating severe cognitive impairment. R15's Care Plan revised on 7/21/21 documents R15 "has potential to demonstrate physical behaviors/having heterosexual behaviors with other residents r/t (related to) Dementia, poor impulse control." This care plan documents R15 had sexual behavior towards another resident on 6/28/21 and physical/intimate contact with a resident on 7/16/21. The facility's undated Facility Incident Report Form documents on 6/6/21 at 9:20 AM R15 and R12 were observed engaging in inappropriate physical contact. The facility's Abuse Investigation Summary dated 6/11/21 documents R15 was sitting in the sunroom and was approached by R12. V22 (Certified Nursing Assistant/CNA) witnessed R12 lift up R12's shirt and R15 made physical contact with R12's chest. R12's Admission Record dated 7/20/21 documents R12 has diagnoses of Disorientation and Dementia without Behavioral Disturbances. R12's Monthly Clinical Summary dated 6/26/21 documents: R12 is alert with short term and long term memory impairment, and is unable to recall current season, location of room, and staff names or faces. R12 is "very demented and cannot	S9999		

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always make needs known."

The facility's undated Facility Incident Report Form documents on 6/6/21 at 9:40 AM R15 made inappropriate physical contact with R19. R15 was seated in the sunroom and was approached by R19. V9 (Activity Aide) saw R15 rub R15's hand across R19's chest.

R19's Admission Record dated 7/20/21 documents R19 has a diagnosis of Alzheimer's Disease. R19's MDS dated 3/4/21 documents R19 has a BIMS score of 8, indicating moderate cognitive impairment.

The facility's undated Facility Incident Report Form documents on 6/28/21 at 11:15 AM R15 had made inappropriate physical contact with R17. The facility's Abuse Investigation Summary dated 7/5/21 documents V3 (Assistant Director of Nursing/ADON) witnessed R15 and R17 in the sunroom. R15's head was on R17's lap, and R17 ran R17's fingers through R15's hair and kissed R15 on the forehead. V3 went to separate R15 and R17 and witnessed R15 put R15's hand under R17's shirt and touch R17's breast. V3 talked with R15 and reminded R15 that R15 was married, and it was not appropriate for R15 to be intimate with others.

R17's Admission Record dated 7/20/21 documents R17 has a diagnosis of Dementia without Behavioral Disturbances. R17's MDS dated 5/20/21 documents R17 has a BIMS score of 4, indicating severe cognitive impairment.

R15's Progress Note dated 6/28/21 at 10:39 AM by V23 (Nurse Practitioner) documents: R15 was evaluated for dementia with behaviors and sexual behaviors. R15 was found to have R15's hand up

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another resident's shirt and fondling (R17's) breast. V23 recommended to "keep distance between female residents" and R15.

The facility's undated Facility Incident Report Form documents on 7/16/21 at 5:30 AM R15 and R17 were sitting in the dining room and R17 had R17's shirt pulled up and R15 was touching R17's breast. The facility's Abuse Investigation Summary dated 7/23/21 documents the following: V24 (CNA) came out of a resident room and saw R15 and R17 in the dining room. R17 had R17's shirt pulled up, R15 was touching R17's breast, and R15's mouth was on R17's breast. V25 (CNA) witnessed R15 and R17 sitting in the dining room. V25 went to the restroom and upon return V25 saw R17 had lifted R17's shirt up. R15 and R17 were separated. V24 reported to V26 (Licensed Practical Nurse/LPN) that R15 and R17 were being sexually inappropriate in the dining room.

There are no documented assessments to determine ability or capacity to consent to sexual interactions located in R12's, R15's, R17's, and R19's medical records.

On 7/19/21 at 3:15 PM R15 was walking the unit independently. R16 was sitting in a wheelchair in the common area watching television. R15 walked up behind R16 and touched the back of R16's neck. V27 (LPN) was present and did not redirect R15 away from R16. On 7/19/21 at 3:21 PM female residents (R16, R4, R22, and R23) were sitting in the common area watching television. R15 walked over and sat in a chair in the common area near R16, R4, R22, and R23. V27 was at the nurse's station in view of R16, R4, R22, R15, and R23, and V27 did not redirect R15 to another area.

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On 7/20/21 at 1:17 PM V30 (LPN) stated that on 6/6/21 around 9:00 AM V30 saw R12 walk towards the day room where R15 was sitting. R12 had stopped and was standing in front of R15, and V30 could no longer see R15. V22 (CNA) went to the day room and told V30 that R12 had lifted R12's shirt up and R15's mouth and hand was on R12's breast. R15 and R12 were separated, and R15 remained in the day room. Shortly after that V9 (Activity Aide) reported to V30 that R15 had rubbed R15's hand across R19's stomach/chest area.

On 7/20/21 at 9:44 AM V9 (Activity Aide) stated that on the morning of 6/6/21 R5 was sitting in the sunroom, R19 was in a wheelchair and approached R15. R15 reached R15's arm out and brushed R15's hand across R19's chest area.

On 7/19/21 at 12:19 PM V3 (ADON) stated on 6/28/21 at about 11:15 AM V3 saw R15 and R17 in the sunroom. R15 had R15's head on R17's lap, R17 was stroking R15's hair, and kissed R15 on the forehead. V3 went to separate R15 and R17. R15 put R15's hand underneath R17's shirt and touched R17's breast before V3 could intervene. V3 stated R15's wife (R20) resides in the facility on another unit.

On 7/19/21 at 2:55 PM V26 (LPN) stated that on 7/16/21 around 5:30 AM V24 and V25 (CNAs) told V26 that R15 and R17 were sexually inappropriate in the dining room. V24 observed R17 standing in front of R15 with R17's shirt pulled up exposing R17's breasts, and R15 was sucking on R17's nipple with R15's mouth. V26 stated R15 and R17 had not exhibited sexual behaviors prior. V26 was not on the unit at the

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time of the incident. There were only two nurses working night shift in the facility on 7/16/21 and V26 was assigned to cover the skilled care unit and the memory care unit.

On 7/20/21 at 11:14 AM V25 (CNA) stated that V25 was hired on 6/16/21. On 7/16/21 around 5:00 AM V24 and V25 were completing resident rounds. V25 went to use the bathroom and saw R17 holding up R17's shirt exposing R17's breasts to R15 in the dining room. R15 and R17 were sitting in the dining room together prior, and V24 and V25 left R15 and R17 to conduct rounds. V26 (LPN) was not on the unit at that time. V25 was not aware that R15 had a history of sexual behaviors, and V25 was not aware of any residents that R15 should not be allowed close to.

On 7/19/21 at 3:21 PM V27 (LPN) stated that V27 witnessed R15 try to lift up R17's shirt up once about 2 months ago exposing R17's stomach. V27 intervened and separated R15 and R17 before "anything further happened." R15 was caught last week with R15's mouth on R17's breast; this is a new behavior for R15. R15's behaviors may be due to R20 no longer residing on the same unit as R15. Staff try to redirect and supervise R15, but it is difficult. R15 is not kept away from any residents, just redirected away from R17.

On 7/20/21 at 9:55 AM V28 (CNA) stated V28 was not aware of any interventions for R15 to be distanced from other residents. V28 stated, "There aren't any residents that (R15) is not able to be near, that I (V28) am aware of."

On 7/20/21 at 11:34 AM V23 (Nurse Practitioner) stated that R15 has had new onset of progressive sexual behaviors. Staff are to discourage R15

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from attending heterosexual activities. V23 expects staff to implement V23's recommendations and supervise R15. V23 gave the example that if R15 is sitting on the couch with a female resident then redirect R15 to another area to eliminate the opportunity and to prevent R15 from touching other residents inappropriately. On 7/20/21 at 1:05 PM V23 stated R15 and R17 are not able to consent to sexual activity. They both have cognitive impairment with some periods of awareness, but they are not able to make safe decisions.

On 7/20/21 at 9:15 AM V1 (Administrator) stated that the resident's ability to consent to sexual interactions is determined by if the resident is oriented to person and situation. R17 was not upset by R15's interactions and R17's family (V29) was ok with R15's and R17's sexual interactions. V1 did not feel the interactions were abuse. The facility cannot provide one to one supervision to prevent abuse and resident behaviors. On 7/20/21 at 1:20 PM V1 stated the facility does not have a policy on sexual interactions between residents and determining residents' ability or capacity to consent to sexual activity.

On 7/20/21 at 10:00 AM V2 (Director of Nursing/DON) stated R12 has a history of flashing people R12's breasts prior to admission. This behavior could appear as inviting and make R12 at higher risk for abuse. R15 and R17 are not cognitively intact, however R15 and R17 have the human need and desire to be intimate. R15 and R17 are not able to cognitively identify risks, consequences and outcomes of their decisions regarding sexual relations. At 5:30 AM the staff are assisting residents out of bed and so it gets "hairy" to supervise the unit at that time. There's

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no excuse, unfortunately the nurse was on another unit, and the CNAs were getting residents up at that time. The facility doesn't have the staff to provide one on one resident care.

On 7/21/21 at 9:58 AM V6 (Social Services Director/SSD) stated that V6 completes the cognitive assessment on the MDS. R15 cannot recall most things and is moderately impaired with decision making. R16, R17, and R19 are moderately impaired with decision making. They require supervision and cues and are somewhat able to make decisions such as picking out clothing. On 7/21/21 at 10:20 AM V6 stated that R12 is borderline with severe impairment with decision making. R15, R17, and R12 are not able to make medical decisions regarding their care. None of the residents gave pushback during the incidents, but it is hard to say at what point a resident with dementia can consent to sexual interaction. R15 has a human need to be sexual, and R15 may not know that the female residents in these instances are not R20 (R15's spouse.) V6 stated, "If (R15) didn't have Dementia, I'm not sure that (R15) would be happy with (R15's) behavior in these instances."

A.2. The Facility's Incident Report Form dated 6/22/21 at 8:45 AM documents R2 was observed by V10 (CNA) exposing R2's genitalia to R8 in the day room. R2's Care Plan dated 7/20/21 documents R2 has been sexually inappropriate with another resident and is affectionate towards other females. This same Care Plan documents R2 is able to make R2's own decisions regarding this matter. V6 (Social Service Director/SSD) stated R2 did not comprehend when asked about the incident.

The facility's Incident Report Form dated 6/26/21

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at 11:15 AM, documents R8 was observed by V10 (CNA) placing R8's hand down R2's pants in the sunroom. R8's Care Plan dated 7/1/21 documents R8 has impaired cognitive function related to Dementia and that R8 has taken a liking to a particular resident and has had inappropriate sexual behavior. This same Care Plan documents R8's Power of Attorney (POA) consent to allowing R8 to have a relationship with this resident as long as R8 is respectful and considerate of those around R8. On 6/28/21 at 11:28 AM, V6 (SSD) stated V6 feels R2 and R8 think R2 and R8 are in a relationship. V6 also stated one other resident (R15) was in the sunroom but does not remember the incident.

R2's MDS dated 4/21/21 documents R2 has a BIMS of 0, indicating severe cognitive impairment. R8's MDS dated 6/18/21 documents R8 has a BIMS of 4, indicating severe cognitive impairment. R2's and R8's medical records do not contain an assessment to determine their ability or capacity to consent to sexual interactions.

On 6/30/21 at 9:30 AM, V1 (Administrator) stated R2 and R8 act like R2 and R8 are boyfriend and girlfriend and both R2 and R8's families have said it's okay for R2 and R8 to have this relationship and to allow R2 and R8 privacy. On 7/26/21 at 2:40 PM, V1 stated, "We don't have an assessment for sexual activity for residents or a policy for sexual activity between residents with dementia." On 6/30/21 at 11:28 AM, V6 (SSD) stated R2 is an affectionate person, he enjoys the ladies, he was in a band previously. V6 stated when the incident occurred on 6/22/21, of R2 exposing R2 to R8, no one else was in the day room. V6 stated R8 did not know anything was inappropriate because R2 and R8 are chummy.

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V6 stated R8 was not upset about this incident and denied it happened. In regard to the incident between R2 and R8 on 6/26/21, V6 stated R8 placed R8's hands down R2's pants and it appeared consensual. V6 stated V6 feels R2 and R8 think R2 and R8 are in a relationship. V6 stated, "We are seeing that now." V6 stated, "Both R2 and R8 are easily redirected but we still investigate." V6 stated one other resident was in the room but was unaware of anything. V6 stated both R2 and R8 will now be followed by V12 (Licensed Clinical Social Worker/LCSW).

There are no documented assessments to determine ability or capacity to consent to sexual interactions in R2 or R8's medical records.

The facility's Daily Census dated 7/26/21 documents R2, R4, R5, R7, R8, R10, R12, R13, R14, R15, R16, R17, R18, R19, R21, R22, R23, R24, R25, R26, R27, R30, and R31 all reside on the facility's dementia unit.

B. The facility's Abuse Prevention Policy dated 11/22/17, documents residents have the right to be free from abuse and the facility prohibits abuse of its residents. This same policy documents Physical abuse includes: hitting, slapping, pinching, kicking, and controlling behaviors through corporal punishment.

B.1. The facility's Abuse Investigation Summary dated 6/17/21, documents V9 (Activity Aide) witnessed R3 grab R4's arm. This report also documents R4 does not recall the altercation, R3 does not remember the altercation, another resident R9, did not see anything, and no other residents are able to be interviewed. V9 stated R3 was sitting in the sunroom in R3's wheelchair in front of R2, R4 was standing close by and began

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talking to R3. R3 grabbed R4's arm. V9 asked R3 to let loose of R4's arm, with R3 stating R4 kicked R3 first (this was not witnessed). V10 (Certified Nurse Assistant/CNA) and V11 (Nurse Assistant/NA) went to help and separated R3 and R4 immediately. Final summary/conclusion documents R3 has anxious and agitative behaviors and it seems R4 was in R3's space. R3 is very close to R2, who was near R3.

The facility's Incident Report "Final" dated 6/23/21, documents investigation complete, interviews with staff and residents determined that R4 tried to take R3's food so R3 attempted to stab R4 with a fork but no contact was made. R4 then slapped R3 on the cheek and R3 bit R4 on the hand. Head-to-toe assessment done with no apparent injuries to either R3 or R4. R3 and R4 were immediately separated. R3 had a room change to a different unit to prevent any further incidents.

R4's Medical Diagnosis Page in R4's Electronic Medical Record (EMR) documents R4's diagnoses as Dementia in Other Diseases Classified Elsewhere with Behavioral Disturbances, Alzheimer's Disease, Pseudobulbar Effect, Generalized Anxiety Disorder. R4's Minimum Data Set (MDS) dated 4/15/21 documents R4 as cognitively impaired and other behavioral symptoms not directed towards others. R4 is not able to be interviewed due to R4 not being able to comprehend questions.

On 7/7/21, at 10:00 AM, V1 (Administrator) stated, "We try to do everything we can to prevent abuse, but how do we know when they (residents) come in if they (residents) will be abusive if they (residents) weren't at home; we do

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not have the staff to do one-on-one with each resident."

B.2. The Physician Order Sheet (POS) dated 7/1/21 documents R4 has diagnoses of Anxiety Disorder, Major Depressive Disorder, and Dementia with Behavioral Disturbance. The Minimum Data Set (MDS) dated 4/15/21 documents R4 is severely cognitively impaired and requires only supervision for ambulation. The Care Plan updated 5/26/21 documents R4 "wanders the unit and wanders in and out of rooms and at times goes through other residents things due to her advanced Alzheimer's" and R4 "demonstrates physical and verbal behaviors towards staff and other residents related to Dementia."

V16's Physician's Note dated 5/12/21 states R4 "Ongoing issues with dementia behaviors. Patient has been more aggressive with staff and other residents. Continues to wander into rooms which does upset some residents."

The POS dated 7/8/21 documents R10 has diagnosis of Dementia without Behavioral Disturbance and Major Depressive Disorder. The MDS dated 3/24/21 documents R10 is severely cognitively impaired. The Social Service Note dated 6/22/21 documents R10 "is anxious, fearful, and worries; also exhibits depressive symptoms (crying, sadness, low motivation)."

R10's Nurses Note dated 6/27/2021 at 8:30 PM states "R4 entered R10's room with two other residents (R8 and R13), woke her, and got her out of her bed. R8 got into R10's bed. R10 was confused and upset and started walking down the hall to the nurse's station. R4 and R13 followed R10. R4 was overheard by staff saying 'you're the

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ugliest bitch ive (I've) ever seen,' upsetting R10 further. R10 was overheard verbally protesting, mostly unintelligible and some expletives at which point R4 slapped R10 in the face. R10 attempted to slap R4 back but contact was not made as staff was able to reach residents by this time. Residents were separated, R4 and R13 escorted to their room and R10 to a chair in the common area and comforted by staff per her preference. R10 did not wish to return to her room at this time but was later agreeable to it and went back to sleep. R4 returned to the nurse's station and her location was closely monitored for the remainder of shift."

On 7/8/21 at 11:23 am V14 (CNA) stated on 6/27/21 during the evening shift V14 witnessed R4 smack R10 in the face as they walked up the hallway toward the nurse's station. V14 stated R10 acted shocked when R4 hit her. V14 stated about 30 minutes prior to R4 hitting R10, R4 wandered into R11's room and woke up R11. V14 stated R11 yelled loudly at R4 and told R4 to get out of her room. V14 stated V14 guided R4 out of R11's room and put R4 back to bed. V14 stated within 30 minutes R4 was out of bed and went into R10's room. V14 stated another time R4 wandered into another resident's room (R12) and when V14 tried to direct R4 out of the room R4 smacked V14 across the face like R4 smacked R10. V14 stated, "(R4) hits pretty good." V14 stated R4 wanders into other resident's rooms a lot and can be aggressive with staff and residents. V14 stated R4 gets out of bed 4-5 times a night and if they don't catch her, she (R4) will be in someone else's room.

On 7/8/21 at 9:48 am V6 (SSD) stated V6 conducted the investigation after R4 hit R10 on 6/27/21. V6 stated R4 has behaviors of physical

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S9999	Continued From page 15 and verbal aggression towards staff and residents and wandering into other resident's rooms. V6 stated R10 was known to have been sleeping in bed before (R4, R8 and R13) wandered into her room. V6 stated R10 then exited her room with R4 and they were walking towards the nurse's station. V6 stated as the nurse was attempting to get to them, R4 smacked R10. V6 stated R4 was upset when she was walking up the hallway with R10 and after being hit she was tearful. V6 stated R4 has advanced dementia and is "very mobile, on the go all the time." No Violation (Violation 2 of 3) 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 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		

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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:

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

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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.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to implement individualized interventions to prevent falls for a resident with a known risk of falls and on blood thinners. This failure affects one (R9) of three residents reviewed for falls in the sample of thirty-three. R9 sustained a subdural hematoma from an unwitnessed fall.

Findings include:

The facility's Falls and Fall Risk, Managing Policy dated Revised August 2008, documents "The staff, with input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls;" and "The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling."

R9's current Electronic Medical Record (EMR) documents R9's diagnoses as: Traumatic Subdural Hemorrhage without loss of consciousness, sequela, Need for assistance with personal care, muscle weakness, repeated falls.

R9's Minimum Data Set (MDS) dated 6/3/21 documents R9 requires extensive assistance of one physical assist for toilet use, is not steady moving from seated to standing position and walking, is cognitively impaired, moderately impaired for daily decision making, and has short

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and long term memory problems.

R9's Baseline Care Plan dated 5/27/21, documents R9 requires assistance for walking/ambulation and toilet use - no individual interventions for walking/ambulation and toileting are documented. This same Baseline Care Plan documents R9 is a fall risk - there are no individual interventions for falls documented. On 7/7/21, at 2:52 PM, V3 (Licensed Practical Nurse/LPN/Assistant Director of Nursing/ADON) stated baseline Care Plans need interventions.

R9's Care Plan dated 6/8/21, documents R9 is at risk for falls related to "repeated falls." R9's Nursing Progress Notes from 5/28/21 through 6/28/21 document nineteen times that R9 had poor balance and gait is unsteady before R9's fall on 6/30/21.

On 7/7/21 at 2:50 PM, V3 (LPN/ADON) stated R9's injuries were not present before R9's fall on 6/30/21, so the injuries must have been caused by the fall. V3 also stated when a resident is a fall risk, the fall protocol is encouraged so all initial interventions are applied to all residents, then after a fall, more specific interventions are added.

On 7/7/21 at 3:00 PM, V13 (Registered Nurse/RN) stated it looked like R9 caught the hinge on the door with R9's head. V13 stated R9 was not using R9's walker at the time and stated R9 is not good about using R9's walker or R9's call light. V13 stated V13 has not documented or reported that R9 does not use R9's walker or call light. V13 stated V13 is not aware of any falls prior to the 6/30/21 fall. V13 stated at the time of R9's fall, R9 was not using R9's walker nor did R9 use R9's call light prior to the fall.

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S9999	Continued From page 19 On 7/9/21, at 12:28 PM, V1 (Administrator) stated, "The ideal would be for those interventions to be listed in the care plan." The hospital report for R9 where R9 was first taken after R9's fall on 6/30/21 documents chief complaint as a fall and a diagnosis of Subdural Hematoma. V15 (Emergency Room (ER) doctor from 6/30/21) documents patient presents with a fall, having an unwitnessed fall at the nursing home, has dementia and does not recall falling; sustained a laceration to the back of head; R9 is on Eliquis (a blood thinner) for Atrial Fibrillation. This same hospital report documents R9 is positive for a back of head wound which is 2.5 centimeters and positive for dizziness and headaches. The imaging results for R9 dated 6/30/21, titled Commuted Tomagraphy (CT) head or brain without contrast documents an impression of Acute Anterior Falx Subdural Hematoma. R9's ER provider notes also document R9 as altered mental status with the hematoma seen extending inferiorly between the low anterior frontal lobes as well. R9's Emergency Department (ED) report dated 6/30/21 also documents patient (R9) is accepted for transfer to another hospital by V17 (ER doctor). The Physician Certification Statement (PCS) dated 6/30/2 at 7:30 PM, documents "Is this a transport to another facility for services not available at the originating facility? YES." (A) (Violation 3 of 3) 300.610a) 300.1210b)	S9999		

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S9999	Continued From page 20 300.1210c) 300.1210d)1) 300.1210d)2) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	S9999		

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S9999	Continued From page 21 seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. These requirements were not met as evidenced by: Facility failures resulted in two deficient practice statements. A. Based on observation, interview, and record review the facility failed to provide prescribed anticoagulant therapy without adequate monitoring for a resident. This failure affects one of five residents (R28) reviewed for anticoagulant use in the sample list of 33 residents. This failure resulted in R28 sustaining lab results for anticoagulant use in the critical range,causing R28 being at unnecessary risk for life threatening complications including hemorrhage and internal bleeding. B. Based on interview and record review the facility failed to administer anticoagulant medications with adequate monitoring as ordered resulting in significant medication errors for four of five residents reviewed for anticoagulants in the sample list of 33 residents. Findings include: A. R28's Admission Record dated 7/28/21 documents R28 admitted to the facility on 5/26/21 with diagnoses including Atrial Fibrillation and displaced subtrochanteric left femur fracture.	S9999		

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R28's Hospital History and Physical dated 5/21/21 documents R28 had a fall at home resulting in a left femur fracture. R28's Fall Risk Assessment dated 6/2/21 documents R28 is at high risk for falls.

R28's Care Plan revised on 6/10/21 documents R28 has Hypertension, Atrial Fibrillation, and Hyperlipidemia. This Care Plan documents the following interventions: Administer anticoagulant medications as ordered. Have antidote Vitamin K on hand for emergencies. Obtain laboratory values as ordered and notify the physician of abnormal results. Monitor, document, and report to the physician signs of anticoagulant complications including blood in urine or stools, black tarry stools, sudden severe headaches, nausea/vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, sudden or significant changes in vital signs.

R28's Order Summary Report dated 6/2/21-7/31/21 documents the following orders: Bactrim (antibiotic) DS (Double Strength) 800-160 milligrams (mg) by mouth twice daily for 10 days starting on 7/19/21, Coumadin (anticoagulant) 1.5 mg by mouth daily from 6/8/21-7/14/21, Coumadin 2 mg daily beginning on 7/14/21, and obtain R28's Protime (PT) and International Normalized Ratio (INR) weekly on Tuesdays and on 7/22/21. Hold Coumadin from 7/20-7/22/21.

R28's July 2021 Medication Administration Record (MAR) documents R28 received Coumadin 1.5 mg daily from 7/1/21 -7/13/21, Coumadin 2 mg daily from 7/14/21-7/19/21, and 7/22/21 -7/26/21, and received Bactrim DS 800-160 mg from 7/20-7/28/21.

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R28's PT-INR Tracking Forms document the following: On 7/6/21 R28's PT was 31.3 and INR was 2.8. On 7/13/21 R28's PT was 20.8 and INR was 1.8. V23 (Nurse Practitioner) gave orders to increase R28's Coumadin to 2 mg daily beginning on 7/14/21 and recheck R28's PT/INR on 7/20/21. On 7/20/21 R28's PT was 77.4 (normal range 8 to 15) and INR was 7.6 (normal range 0.7 to 1.2). There is no documentation in R28's medical record that a PT/INR was obtained on 7/22/21 as ordered. R28's INR/Protime, PT, Therapeutic laboratory results dated 7/27/21 at 5:05 PM documents R28's INR was 8.05 (critical value.)

R28's Nursing Notes document that on 7/12/21 R28 did not receive Coumadin 1.5 mg as ordered with the documented reason as "none available." On 7/19/21 the Bactrim DS order entry triggered a warning of a possible drug interaction with Coumadin that could cause a severe interaction of increased hypoprothrombinemic (prolonged bleeding) effects. There is no documentation in R28's medical record that the potential drug interaction warning was communicated to V16 (Physician) or V23 (Nurse Practitioner) to review. On 7/20/21 at 6:21 AM V16 was notified of R28's critical level of 7.6 and gave orders to draw INR and send to the laboratory for testing. At 2:41 PM R28's INR was 5.47 and orders were received to hold Coumadin until Thursday (7/22/21) and recheck INR on 7/22/21. On 7/27/21 at 4:50 PM V23 (Nurse Practitioner) was notified of R28's INR results and gave orders to hold Coumadin for 2 days, administer Vitamin K 1 mg Intramuscularly, monitor for bleeding, and repeat INR daily for 2 days.

On 7/28/21 at 10:58 AM the facility's (PT/INR

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monitoring system, machine) was reviewed with V2 (Director of Nursing) and contained an electronic entry for R28's results on 7/27/21 of PT 94.7 and INR 8.

On 7/27/21 at 4:16 PM V13 (Registered Nurse) stated on 7/12/21 there was no Coumadin medication card for R28 in the medication cart. V13 stated V13 did not contact the pharmacy or access the (Emergency Medication System) to obtain the medication and did not notify V16 (Physician) or V23 (Nurse Practitioner). V13 stated, "I documented the medication wasn't available and passed it onto the next shift."

On 7/27/21 at 2:27 PM V31 (Licensed Practical Nurse/LPN) stated that on 7/20/21 around 6:21 AM V31 notified V16 (Physician) of R28's elevated PT/INR results. V16 gave orders to hold Coumadin until 7/22/21 and redraw PT/INR on 7/22/21.

On 7/27/21 at 2:30 PM V2 (Director of Nursing) stated that the PT-INR Tracking Form is returned signed by the physician, and the nurse should enter the order in the electronic medical record (EMR). V2 confirmed there is no documentation in R28's medical record that a PT/INR was obtained on 7/22/21. On 7/27/21 at 3:43 PM V2 stated that when V31 entered the order to draw PT/INR on 7/22/21 into R28's EMR, it did not carry over to the MAR to prompt the nurse to obtain the PT/INR and sign the MAR. V2 would expect R28's PT/INR to have been drawn as ordered and the results reported to the physician prior to resuming R28's Coumadin on 7/22/21, since R28's previous PT/INR was high. On 7/28/21 at 9:40 AM V2 stated the facility has a (Emergency Medication System) that contains a supply of medications for backup or emergencies.

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If the resident does not have a medication available, the nurse should check the (Emergency Medication System) to obtain the medication. If the medication is not available, then the nurse should contact the pharmacy to have the medication delivered. The physician should be notified if a resident misses a dose of medication. On 7/29/21 at 1:55 PM V2 stated the nurses should notify the physician of potential drug to drug interactions and document in the nursing notes. On 7/29/21 at 2:27 PM V2 stated V32 (LPN) told V2 that V32 did not notify V16 or V23 of the potential drug interaction between Bactrim DS and Coumadin, and there is no documentation in R28's medical record that V16 or V23 were notified.

On 7/28/21 at 11:14 AM V16 (Physician) stated, "Ideally with R28 I should have been notified of the missed dose of Coumadin, since the next day R28's PT/INR was low, and the dosage of Coumadin was increased. Missing one dose of Coumadin could affect the PT/INR depending on the resident's sensitivity to the medication and each resident is different." V16 was notified of R28's PT/INR results on 7/20/21 and gave orders to hold Coumadin for 3 days and obtain PT/INR results on 7/22/21. V16 intended for the Coumadin not to be held until after V16 was notified of the PT/INR results on 7/22/21. R28's PT/INR results on 7/27/21 put R28 at risk for bleeding if R28 were to fall, and at risk for GI (gastrointestinal) or nose bleeding, which can be life threatening. GI bleeding can go undetected.

On 7/29/21 at 12:29 PM V33 (Pharmacist) stated the therapeutic target INR for someone with Atrial Fibrillation would be between 2 and 3. The most common risks associated with prolonged critical INRs would be bruising, and bleeding such as in

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the stool or urine. Without monitoring PT/INR it may not be known that the resident has a high level. The PT/INR should be checked every couple of days following a dosage change until the INR returns to the target range. If there would be uncontrolled bleeding it could be life threatening.

On 7/29/21 at 1:28 PM V34 (Pharmacist) stated R28's elevated INR was likely due to the interaction between Coumadin and Bactrim DS. Bactrim is one of the worst medications to give with Coumadin; it has the potential for severe interaction and increases the effects of Coumadin. INR is recommended to be checked 48 hours after starting Bactrim.

The facility's undated (Emergency Medication System) Inventory List documents the system contains Coumadin 1 mg, 2.5 mg, and 5 mg tablets, and Lovenox (anticoagulant) 60 mg/0.6 ml (milliliter) syringes.

The Prescribing Information for Coumadin revised August 2012 documents an INR of greater than 4 is associated with a higher risk of bleeding, and the most common adverse reactions are fatal and nonfatal hemorrhage (bleeding) from tissues or organs. Maintain a target INR of 2.5 (INR range 2.0-3.0).

The facility's (PT/INR Monitoring System) User's Manual with a copyright date of 2019 documents: "Blood-Clotting Time: The rate at which blood clots is measured in units is called International Normalized Ratio (INR). It is very important for patients to stay within their individual target INR range. If the INR is too low, the risk of blood clots increases. If the INR is too high, the risk of hemorrhaging increases. The patient's physician

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will determine the most appropriate INR range for the patient, depending upon the patient's indication and how they respond to the oral anticoagulants." This manual documents the normal range for PT is 8.0 to 15.0 and INR is 0.7 to 1.2.

The facility's Orders for Anticoagulants Policy dated February 2014 documents the following: "1. Prior to initiating a warfarin regimen, a baseline International Ratio (INR) will be obtained and results reported to the Attending Physician. Follow-up INRs will be determined by the Attending Physician. 2. Anticoagulant therapy orders will be administered as ordered by the Attending Physician. 3. The Attending Physician must periodically review the recorded results of the laboratory monitoring and review for complications. 4. Should a resident receiving an anticoagulant have a fall and sustain a serious injury, (i.e. (for example) head injury, laceration, etc. (etcetera)) the Attending Physician must be notified and the resident must be observed closely for bleeding or changes in mental status. (Note other medications or foods may interact with the anticoagulant and increase the risk of bleeding.)"

B.1. R33's Care Plan revised 8/20/20 documents R33 receives Coumadin with interventions including to obtain labs as ordered and report results to the physician, and monitor/document/report to physicians signs of blood in urine and stools, sudden severe headaches, nausea/vomiting/diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status or vital signs.

R33's Progress Note dated 5/26/21 at 3:08 PM by

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V16 (Physician) documents R33 receives an anticoagulant due to a valve replacement, and R33's INR goal is 2.5-3.5.

R33's Order Review Report dated 8/2/21 documents the following orders: Coumadin (anticoagulant) 3 mg (milligrams) by mouth daily on Monday-Thursday, Sunday, and 4 mg daily on Friday and Saturday from 5/26/21-7/6/21. Coumadin 4 mg daily from 7/6/21-7/23/21. Coumadin 3 mg daily from 7/23/21-7/25/2. Coumadin 3.5 mg daily from 7/25/21-7/31/21. INR weekly on Tuesdays starting on 6/15/21. Administer Lexapro 20 mg by mouth daily, multivitamin one tablet by mouth daily, Tylenol 1000 mg by mouth at bedtime, and Synthroid 75 mcg (micrograms) by mouth daily.

R33's July 2021 Medication Administration Record (MAR) documents to refer to the nursing notes for Coumadin administration on 7/4/21 and 7/28/21. R33's Progress Note dated 7/4/21 at 5:13 PM by V13 (Registered Nurse/RN) documents Coumadin 3 mg was not administered, "not available." R33's Progress Note dated 7/28/21 at 6:15 PM by V13 documents Coumadin 3.5 mg was not administered, "none available." There is no documentation in R33's medical record that V16 (Physician) or V23 (Nurse Practitioner) was notified of R33's missed doses of Coumadin.

There is no documentation in R33's medical record that INR was completed on 6/15/21 and 7/20/21 as ordered. R33's PT-INR Tracking Forms document the following: R33's INR was 2.6 on 6/8/21 and 2.5 on 6/16/21. R33's INR was 2.7 on 7/13/21 and 4.5 on 7/22/21.

R33's Progress Note dated 7/21/21 at 9:50 PM by

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V23 (Nurse Practitioner) documents R33 was evaluated for vaginal bleeding, R33's last PT/INR was 7/13/21, and an order to continue weekly INR. R33's Progress Notes on 7/6/21 and 7/23/21 document R33's Coumadin order entry triggered a warning of a possible drug interaction with Synthroid that could cause a severe interaction of increased hypoprothrombinemic (prolonged bleeding) effects, and moderate risk of interaction with Lexapro, Multivitamin, and Tylenol. There is no documentation in R33's medical record that V16 or V23 were notified of the potential drug interactions.

On 8/2/21 at 1:10 PM V31 (Licensed Practical Nurse/LPN) stated on 7/20/21 the residents were participating in an activity outside and V31 did not complete R33's INR. V31 passed it on to the next shift to be completed.

On 8/2/21 at 11:49 AM V3 (Assistant Director of Nursing) stated that on 7/30/21 V3 re-entered orders for PT/INR to populate onto the MAR. Prior to 7/30/21 the orders for PT/INR were not populating to the MAR/TAR to be signed out by the nurse. V3 confirmed R33's Coumadin was not given on 7/4/21 and 7/28/21. V13 (RN) should have obtained the Coumadin from the facility's (Emergency Medication System) to administer to R33. V13 needs more one on one supervision on following this procedure. On 8/2/21 at 3:07 PM V3 stated V3 was unable to provide documentation that an INR for R33 was drawn on 6/15/21 or 7/20/21 as ordered, or that V16 or V23 were notified of the potential drug interactions with Coumadin.

On 7/28/21 at 9:40 AM V2 (Director of Nursing) stated the facility has an (Emergency Medication System) that contains a supply of medications for

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backup or emergencies. If the resident does not have a medication available, the nurse should check the (Emergency Medication System) to obtain the medication. If the medication is not available, then the nurse should contact the pharmacy to have the medication delivered. The physician should be notified if a resident misses a dose of medication.

B.2. R15's Admission Record dated 7/19/21 documents R15 admitted to the facility on 12/29/20 and R15 has a diagnosis of Atrial Fibrillation. R15's Order Review History Report dated 7/28/21 documents an order to administer Eliquis (anticoagulant) 5 mg by mouth twice daily.

R15's July 2021 MAR does not document R15 received Eliquis as ordered on 7/4/21 at 5:00 PM and 7/24/21 at 5:00 PM with the documented reason as "Absent from home/hospitalized."

R15's Nursing Notes document the following: On 7/4/21 R15 was transferred to the local hospital at 3:05 PM and returned to the facility at 6:00 PM. On 7/24/21 R15 was transferred to the local hospital at 2:01 PM and returned to the facility at 9:50 PM There is no documentation that R15 received Eliquis as ordered, or that the hospital was contacted to determine if R15's evening medications were administered. There is no documentation that V16 (Physician) or V23 (Nurse Practitioner) were notified of R15's missed doses of Eliquis.

On 7/29/21 at 1:04 PM V2 (Director of Nursing) stated that if (R15) returned at 6:00 PM the nurse should have given R15's scheduled 5:00 PM medications after verifying that the hospital did not administer the medications, and document in the medical record. V2 confirmed there is no

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documentation that R15 received Eliquis 5 PM dose on 7/4/21 and 7/24/21, that the hospital was contacted to determine if medications were given, or that V16 or V23 were notified of the missed doses.

On 7/28/21 at 11:14 AM V16 (Physician) stated that if a resident returns from the emergency room, the facility staff should verify with the hospital whether or not medications were given, and notify V16 if medications are not given. V16 stated, "This has been a problem. We have discussed medications not being delivered from pharmacy and medications not being administered at the facility's last Quality Assurance meeting."

The facility's undated (Emergency Medication System) Inventory List (on site) documents the system contains Coumadin 1 mg, 2.5 mg, and 5 mg tablets, and Lovenox (anticoagulant) 60 mg/0.6 ml (milliliter) syringes.

The facility's Orders for Anticoagulants Policy dated February 2014 documents the following: "1. Prior to initiating a warfarin regimen, a baseline International Ratio (INR) will be obtained and results reported to the Attending Physician. Follow-up INRs will be determined by the Attending Physician. 2. Anticoagulant therapy orders will be administered as ordered by the Attending Physician. 3. The Attending Physician must periodically review the recorded results of the laboratory monitoring and review for complications. 4. Should a resident receiving an anticoagulant have a fall and sustain a serious injury (i.e. (for example) head injury, laceration, etc. (etcetera)) the Attending Physician must be notified and the resident must be observed closely for bleeding or changes in mental status.

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(Note other medications or foods may interact with the anticoagulant and increase the risk of bleeding.)"

The facility's Guidelines for Notifying Physicians of Clinical Problems dated as revised April 2007 documents the physician will be notified of significant medication errors.

B.3. R29's Physician Order Sheet (POS) dated 7/1/21 through 7/31/21, documents an order for Enoxaparin Sodium Solution (Lovenox anticoagulant) 40milligrams (mg)/0.4milliliter (ml), inject 0.4 ml (40 mg) subcutaneous everyday prophylactic for 21 days.

R29's Discharge Transfer Orders dated 7/17/21 documents rest and elevate extremity as needed to control pain and swelling for fracture of right femur, right fibula, right shoulder.

R29's Care Plan dated 7/19/21 documents R29 is at risk for falls related to gait/balance problems due to fracture of right femur, right shoulder, and right fibula. This same Care Plan documents R29 is unaware of safety needs. There is no documentation on R29's current Care Plan that addresses to give anticoagulants as ordered or to monitor, document, and report complications of bleeding to the physician.

R29's Medication Administration Record (MAR) dated 7/1/21 - 7/31/21, documents a number "3" which according to the MAR, indicates R29 was absent from the facility on 7/21/21. There is no further documentation in R29's Medical Record that the anticoagulant (Lovenox) was ever given to R29 on7/21/21.

On 7/28/21 at 11:16 AM, V6 (R29's Physician)

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stated if a medication, specifically Lovenox (anticoagulant) is missed because a resident had an appointment, V6 would expect nursing staff to give the medication when the resident returns to facility. V6 also stated the risk of missing a dose of an anticoagulant would be developing a blood clot due to immobility. V6 also stated the nursing staff document that medications have "not arrived" to the facility from the pharmacy when the medication is at the facility in the emergency medication dispensing system. V6 stated management is aware the staff nurses are not aware of the medications in the emergency medication dispensing system and that the staff nurses need to be re-trained to use the emergency medication dispensing system correctly.

B.4. R32's routine physician visit dated 6/30/21 documents R32's diagnosis as Atrial Fibrillation.

R32's Order Review Report, dated 4/1/21 through 8/21/21, documents an order for Coumadin (anticoagulant) tablet, give 2 milligrams (mg) by mouth in the afternoon, with a start date of 7/31/21. This same report documents an order for 4/27/21, to repeat INR weekly one time a day every Tuesday. This same report documents an order to repeat R32's International Normalized Ratio (INR) on 4/27/21. R32's Nursing Progress Notes dated 4/27/21 documents INR less than 0.8 and Prothrombin Time (PT) 3.0, continue same dose (of coumadin) and repeat PT/INR on 4/28/21. This repeat PT/INR was not done until 5/4/21. This documentation was verified by V3 (Licensed Practical Nurse/LPN/Assistant Director of Nursing/ADON) on 8/2/21 at 3:12 PM. R32's Order Administration Note dated 6/1/21 at 5:36 PM, documents PT 47, INR 4.4, hold coumadin

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S9999	Continued From page 34 for 3 days and restart at 2 mg. R32's Medication Administration Record (MAR) dated June 2021, documents coumadin held on 6/2/21, 6/3/21, 6/4/21, 6/5/21, 6/6/21, and 6/7/21, and restarted on 6/8/21 at 2 mg. R32's Progress Note dated 6/8/21, documents PT 13.7 and INR 1.2 and restart coumadin 2 mg daily, repeat INR next Tuesday (6/15/21). On 8/2/21 at 3:12 PM, V3 (LPN/ADON) verified this information. R32's Progress Note dated 7/6/21 documents repeat INR on Friday the 9th (June). R32's Progress Note dated 7/14/21, documents the next lab draw on 7/14/21. On 8/2/21, at 3:12 PM, V3 (LPN/ADON) verified the lab for R32 was not drawn on 6/9/21 as ordered. R32's Care Plan dated 6/3/21 documents R32 is on an anticoagulant and to give medications and labs as ordered. (B)	S9999		