STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007488	A. BUILDING: _____ B. WING _____	C 09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MEADOWS SENIOR LIVING	400 WEST WASHINGTON CHRISMAN, IL 61924

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2166569/IL137945 Facility Reported Incident 8-27-21/IL137955	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 2) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) 300.3240f) 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	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 300.3240 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 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: Based on interview and record review the facility failed to supervise a resident (R1) with a known history of inappropriate sexual resident to resident contact, to prevent resident to resident sexual abuse. This resulted in R2 being sexually abused by R1. R1 and R2 are two of 22 residents reviewed for abuse in the sample list of 27. Staff allowed R1 unrestricted access, exposing residents (R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21,	S9999		

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S9999	Continued From page 2 R22, R23, and R24) on the unit who are unable to consent to sexual interactions, to potential sexual abuse. Findings include: The facility's Abuse Investigative Summary dated 9/3/21 documents the following: On 8/27/21 R1 and R2 were discovered exhibiting sexual behavior. V13 (Certified Nursing Assistant/CNA) responded to a sounding bed alarm and called for V12's (CNA) assistance. When V12 left the nurse's station, R1 was sleeping in a recliner and R2 was sitting in the dining room. When V12 and V13 returned, R1 was in the dining room performing sexual acts on R2. R1 and R2 were separated. V18 (CNA) was on R1's and R2's unit all night, and V18 had to go to the skilled unit to assist with a resident's care. R2 was the only resident awake when V18 left the unit, a few minutes before the incident between R1 and R2 occurred. There was no documentation that R1 and R2 were supervised by staff at this time. R1 and R2 were separated and were upset with staff intervening. This summary documents, "(local police) do not feel a crime was committed as no one was forced against their will to participate therefore abuse was not substantiated." R1's Admission Record dated 9/13/21 documents R1 has a diagnosis of dementia with behavioral disturbances. R1's Minimum Data Set (MDS) dated 7/7/21 documents a Brief Interview for Mental Status (BIMS) score of 2, indicating severe cognitive impairment. R1's Care Plan revised on 9/13/21 documents: R1 has sexual behaviors as well as physical aggression towards staff and residents. R1 had sexual behaviors towards another resident on	S9999		

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S9999	Continued From page 3 6/28/21, accidental physical contact with a resident on 7/5/21, physical/intimate contact with a resident 7/16/21, and physical contact with another resident on 8/27/21. R1 has a history of inappropriate sexual interactions with R2 on 6/28/21 and 7/16/21, with R7 and R9 on 6/6/21. R1's Progress Note dated 6/28/21 at 10:39 AM by V19 (Nurse Practitioner) documents: R1 was evaluated for dementia with behaviors and sexual behaviors. R1 was found to have R1's hand up another resident's shirt and fondling breasts. V19 recommended to "keep distance between female residents." R2's Admission Record dated 9/13/21 documents R2 has a diagnosis of dementia. R2's MDS dated 8/19/21 documents: R2 has a BIMS score of 0, indicating severe cognitive impairment. R2 has disorganized thinking. R2's Care Plan documents R2 has shown an interest in a specific male resident (R1), (R2) seeks (R1) out, and shows a romantic interest in (R1). R2's care plan includes interventions to monitor time spent with other resident (in which there is a history of intimate contact), provide reality orientation, engage in an activity that does not involve the other resident, redirect with a snack/drink, if (R1 and R2) are together, monitor their behaviors, if showing romantic physical attention towards each other attempt to separate, and assure R2's safety. On 9/13/21 at 3:46 PM V13 (CNA) stated, "On 8/27/21 between 2:30-3:00 AM I (V13) heard a bed alarm sounding and went to assist the resident. I (V13) called for V12's assistance leaving R1 and R2 unsupervised. At that time R2 was sitting in a chair in the dining room and R1 was asleep in a recliner across from the dining room. When V12 and I (V13) returned to the unit	S9999		

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S9999	Continued From page 4 R2 was sitting in a chair in the dining room with R2's pants down. R1 was on R1's knees in front of R2, and R1's face was in R2's genital area. I (V13) and V12 immediately separated R1 and R2. We try to keep one person watching R1 at all times and keep R1 and R2 separated. A lot of times I (V13) am assigned to that unit by myself, sometimes there are two CNAs. The nurse doesn't come to the unit until 4:00 AM. It is hard to keep an eye on (R1) when we are in resident rooms completing rounds." On 9/14/21 at 2:19 PM V12 (CNA) stated, "I (V12) and V13 worked night shift on R1's unit on 8/26/21. Prior to R1's/R2's incident R2 was in the dining room and R1 kept trying to go into the dining room with R2. I (V12) and V13 had to keep separating R1 and R2 and tried to redirect R2 to R2's room. R2 kept returning to the dining room. R1 was combative with me (V12) and V13 when we separated R1 and R2. Sometime close to 3:00 AM V13 went to a resident's room to respond to a bed alarm. V13 called for my (V12) assistance and I (V12) left R1 and R2 to assist V13. When I (V12) and V13 returned from providing resident care, R1 and R2 were in the dining room. R2 was sitting with R2's pants pulled down. R1 was kneeling in front of R2, and R1 was licking R2's genital area. I (V12) and V13 immediately separated R1 and R2. R1 and R2 like to kiss and hug each other, and we try to watch them and keep them separated. We try to have three CNAs on the unit but that doesn't always happen." V12 confirmed there were no other staff on the unit to monitor R1 and R2 when V12 and V13 left them unattended. On 9/14/21 at 9:15 AM V1 (Administrator) stated, "The facility has been trying to staff three employees on R1's/R2's unit, with the intention of	S9999		

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S9999	Continued From page 5 having one employee supervising the residents on the unit. V13 called me about 3:15 AM on 8/27/21 to report R1's/R2's incident that happened around 3:00 AM. V18, V13, and V12 (CNAs) were assigned to R1's/R2's unit. V18 had left the unit to assist with a resident's care on the skilled unit. V13 responded to a resident's bed alarm. V13 called for V12's assistance. At that time R1 was asleep in the recliner near the entrance to the unit, and R2 was in the dining room. When V12 and V13 returned, R2 was sitting in the dining room with R2's pants pulled down. R1 was kneeling in front of R2 and was kissing R2's thighs. Staff have been trained to call the other unit to have staff come assist or monitor the unit. Residents with a diagnosis of dementia do not have the ability to consent to sexual activity." V1 confirmed all residents on (R1's/R2's) unit have cognitive impairment. The facility's Daily Census dated 8/27/21 documents 22 residents (R1, R2, and R5-R24) reside on R1's/R2's unit. The facility's Facility Assessment updated on 8/19/21 documents: "This unit (R1's/R2's unit) is where our residents live that are suffering from Dementia or Alzheimer's and are still able to participate in programming for this condition, or are an elopement risk and cannot be placed outside of a locked unit. The staff of this unit undergo additional training for Dementia/Alzheimer's disease to ensure that they are equipped for the behaviors and occurrences on this unit." (B) (Violation 2 of 2)	S9999		

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S9999	Continued From page 6 300.610a) 300.1210b) 300.1210c) 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. 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.	S9999		

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S9999	Continued From page 7 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 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 observation, interview and record review the facility failed to: develop and implement fall interventions for self-transfers for a resident, complete post fall neurological assessments after a resident's unwitnessed fall,	S9999		

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S9999	Continued From page 8 ensure thorough fall investigations were completed and ensure resident fall interventions were implemented. This failure affects three of three residents (R3, R4, R5) reviewed for falls on the sample list of 27 residents. R3 was known to be at high risk for falls, required staff assistance for ambulation, had incontinence care needs, and was at risk for life threatening complications including hemorrhage and internal bleeding due to receiving antiplatelet medication. R3 fell, suffered a subdural hematoma, and died after staff failed to develop and implement fall interventions for self-transfers. R4 fell and suffered a fractured arm after staff failed to ensure a motion sensor alarm was present in R4's room. Findings include: 1. The Facility Clinical Admission Evaluation dated 8/4/21 documents R3 has some confusion, disorganized thinking, and short-term memory loss and that R3 is continent of bowel and incontinent of urine. The Admission Evaluation documents R3 has an unsteady gait and poor balance. The Fall Risk Assessment dated 8/4/21 documents R3 is at high risk for falls. The Hospital Discharge Summary dated 8/4/21 documents R3 has a diagnosis of Cognitive Decline and Impairment and that R3 has had recent falls at home. The Discharge Summary documents R3 has speech difficulty and gait impairment and that R3 was brought to the Emergency Department by R3's family due to concerns related to worsening cognitive decline and ability to care for R3's self at home. The Nurse's Note dated 8/4/21 documents R3 was admitted to the facility on that date from the	S9999		

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S9999	Continued From page 9 hospital. The Physician Order Sheet dated 8/1/21-8/31/21 documents R3 has diagnoses of Dementia, Anxiety Disorder, Parkinson's Disease, Overactive Bladder, Retention of Urine and Repeated Falls. The Physician Order Sheet also documents an order for R3 to have Plavix (antiplatelet) 75 milligrams in the morning for a history of Transient Ischemic Attack and Cerebral Infarction. The undated Plavix Prescribing Information sheet states Plavix "increases the risk of bleeding." R3's Baseline Care Plan dated 8/4/21 documents R3 is unsafe with independent transfers, has poor standing balance and should transfer with staff assistance and a gait belt. The Baseline Care Plan documents R3 needs staff assistance for walking, locomotion, dressing, hygiene, and toilet use. The Baseline Care Plan does not document that R3 self-transfers or include interventions to address self-transferring. The Baseline Care Plan does not document a plan for toileting or incontinence care for R3. The Care Plan dated 8/4/21 documents R3 is at high risk for falls due to deconditioning and gait and balance problems and documents the following fall interventions: Be sure R3's call light is within reach and encourage R3 to use it for assist and as needed; Ensure R3 is wearing proper footwear when ambulating or mobilizing in wheelchair; Follow facility fall protocol; R3 needs activities that minimize the potential for falls while providing diversion and distraction; Keep furniture in locked position; Keep needed items (water, etc.) in reach; R3 needs a safe environment; Maintain a clear pathway in room. R3's care plan	S9999		

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S9999	Continued From page 10 does not document that R3 self-transfers or include interventions to address self-transferring. R3's Care Plan dated 8/4/21 does not address a plan for toileting or incontinence care for R3. The Fall Incident Description dated 8/6/21 documents, "(R3) was found on the floor in (R3's) bathroom. (R3) had apparently taken (R3's self) in to use the toilet. (R3's) dementia gives (R3) poor safety awareness. There was feces and urine in (R3's) depends and on the outside of them. (R3) apparently felt an urgency to use the bathroom and did not use the call light or wait for assistance. Nurse Practitioner (V19) was first to respond and noted a laceration approx. (approximately) one inch on the back of (R3's) head. First aid immediately performed to control the bleeding. Vitals taken. Nurse Practitioner ordered to send to ER (Emergency Room) for an evaluation." The Fall Summary of Events dated 8/10/21 documents, "Nurse Practitioner (V19) entered room at 2:45 PM (on 8/6/21) to do an initial assessment and to meet (R3) and discovered (R3) on the floor in the bathroom. (R3) was laying at a diagonal on the floor with (R3's) head bleeding. There was feces and urine all over the floor as well as smeared on the toilet paper dispenser and the wall above it. There was feces and urine on the inside and outside of (R3's) (brief). (Brief was) pulled down." The Fall Summary of Events, Staff Interviews and Fall Timeline dated 8/10/21 for R3's 8/6/21 fall and the Fall Incident Description dated 8/6/21 do not document when R3 was last toileted or received incontinence care before being found on the floor in the bathroom. R3's Bowel and Bladder Continence Records dated August 2021 do not	S9999		

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S9999	Continued From page 11 document R3 was toileted or received incontinence care during the day or evening shifts on 8/6/21. The Hospital Discharge Summary dated 8/8/21 documents R3 was admitted to the hospital on 8/6/21 after falling at the facility and a Computed Tomography of R3's brain showed a large subdural hematoma. The Discharge Summary dated 8/8/21 documents "Although patient's (R3) code status is DNR (Do Not Resuscitate), family requested intubation. Neurologic status continued to deteriorate." The Discharge Summary documents R3 died at the hospital on 8/8/21. On 9/13/21 at 2:15 pm V6 (Certified Nursing Assistant/CNA) stated on 8/4/21 R3 was "up and down and up and down" by R3's self. V6 stated V6 observed R3 standing by the bed in R3's room a couple of times and found the urinal with urine in it on the night table, which was not located within arm's reach of the bed. V6 stated V6 guessed R3 got out of bed, used the urinal, and then got back in bed. V6 stated the evening of 8/4/21 V6 assisted R3 to the chair and R3 was weak and unsteady. V6 stated later that evening V6 found R3 back in bed. V6 stated R3 had the call light in the chair, but R3 did not use it to call for assist to get back in the bed. V6 stated V6 reported to the (unknown) nurse that R3 was getting up and down by R3's self. On 9/13/21 at 12:55 PM V5 (CNA) stated R3 was incontinent at times and they also took R3 to the bathroom. V5 stated V5 remembers walking by R3's room and seeing R3 standing in R3's room unassisted. V5 stated V5 assisted R3 to walk to the bathroom and R3 was unsteady. On 9/13/21 at 1:20 pm V7 (CNA) stated V7 was	S9999		

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S9999	Continued From page 12	S9999		

assigned to R3's unit on 8/6/21 for the 6:00 am to 2:00 PM shift. V7 stated in the morning V7 observed R3 in the bed. V7 stated V7 spoke with R3 between breakfast and lunch and at that time R3 was in the doorway of R3's room in the wheelchair and R3 wanted an incontinence brief and ice water. V7 stated V7 picked up R3's lunch tray around 12:30 pm and R3 was back in the bed. V7 stated V7 assumed R3 was transferring R3's self. V7 stated V7 did not see R3 on 8/6/21 after picking up R3's lunch tray. V7 stated V7 did not transfer R3 during the shift, and V7 did not take R3 to the bathroom or check R3's incontinence brief during the shift.

On 9/13/21 at 5:30 pm V9 (Registered Nurse/RN/Assistant Director of Nursing/ADON) stated V9 was R3's nurse for the 6:00 am to 2:00 PM shift on 8/6/21. V9 stated V9 checked on R3 when the CNA (V7) was picking up R3's lunch tray between 12:30 and 1:00 pm. V9 stated at that time R3 was lying in bed. V9 stated V9 did not transfer R3 or take R3 to the bathroom during V9's shift. V9 stated V9 did not ask R3 if R3 needed to use the bathroom during V9's shift. V9 stated V9 did not know R3 was getting up by R3's self.

On 9/14/21 at 8:45 am V8 (Licensed Practical Nurse/LPN) stated V8 relieved another nurse (V9) at 2:00 PM on 8/6/21. V8 stated V8 did not see R3 during the shift until R3 was found on the floor in the bathroom by V19 (Nurse Practitioner). V8 stated when V8 arrived R3 was on the floor in the bathroom under the sink, and R3 had a head wound that was bleeding. V8 stated R3 had been incontinent of bowel and bladder. V8 stated R3 was not supposed to be up by R3's self. V8 stated R3 had fallen prior to being admitted to the facility, and R3 was a high fall risk. V8 stated V8

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S9999	Continued From page 13 did not know R3 was getting up without assist. On 9/15/21 at 11:25 am V3 (Assistant Director of Nursing/ADON) stated V3 initiated R3's Care Plan with the standard facility fall interventions. V3 stated after the fall assessment was completed, staff should have implemented fall interventions appropriate for R3. V3 stated V3 did not know R3 was self-transferring until R3 fell on 8/6/21. V3 stated if V3 had known R3 was self-transferring, V3 would have placed (bed and chair) alarms to alert staff R3 was getting up. V3 stated R3 was a high fall risk and had a bedside sitter at the hospital before being admitted to the facility. V3 also stated staff should have been providing incontinence care for R3 and toileting R3. V3 confirmed R3's fall investigation and medical record do not document when R3 was last toileted or received incontinence care before R3 was found on the floor in the bathroom. V3 stated the nurses should have included this information in their documentation. On 9/14/21 at 1:30 pm V19 (Nurse Practitioner) stated on 8/6/21, V19 was going to see R3 as a new admit and found R3 on the floor in the restroom. V19 stated R3 had a laceration on R3's head. V19 stated R3 suffered the head injury when R3 fell. V19 stated V19's concern and fear was that R3 was on Plavix and had had a brain bleed. V19 stated emergency responders arranged for R3 to be flown by helicopter to the hospital. V19 stated later the nursing home staff told V19 that R3 died at the hospital. V19 stated R3 had cognitive impairment and tried to get up independently, but R3 was not capable of being up independently. V19 stated V19 would expect facility staff to have interventions in place to prevent falls.	S9999		

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S9999	Continued From page 14 On 9/14/21 at 4:40 pm V29 (Physician) stated V29 reviewed R3's hospital record and stated, "The fall is the culprit." V29 stated according to the medical record the subdural hematoma resulted from the fall and the subdural hematoma caused R3's death. 2. The Physician Order Sheet dated 7/1/21 through 7/31/21 documents R4 has diagnoses of Dementia with Behavioral Disturbance, Unsteadiness on Feet and a History of Falling. The Minimum Data Set (MDS) dated 6/18/21 documents R4 is severely cognitively impaired, requires staff assistance with transfers, ambulation and toileting and that R4 is continent of bowel and bladder. The Fall Care Plan initiated 12/15/20 documents an intervention dated 4/1/21 for R4 to have a motion sensor alarm in order to alert staff of R4's movements and an intervention dated 7/5/21 for "staff to ensure proper placement and function of motion sensor alarm Q (every shift)." R4's Self Care Deficit Care Plan initiated 1/15/21 states, "Provide incontinence care when any episode of incontinence occurs," and "Encourage and assist (R4) in using the restroom upon rising/before bed, before/after meals and upon request." V22's (Licensed Practical Nurse/LPN) Nurse's Note dated 7/1/21 documents R4 "noted sitting on the floor hit left forehead small 2 cm (centimeter) laceration area cleansed and steri strip applied." The Fall Report dated 7/1/21 does not document R4's motion sensor alarm was in place when R4 was found on the floor. The Fall Report documents a root cause of "(R4) continues with poor safety awareness and impaired judgement related to cognitive impairments ambulating in	S9999		

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S9999	Continued From page 15 room without staff assistance. Intervention: Staff to ensure proper placement and function of motion sensor alarm Q (every) shift." V24's (Registered Nurse/RN) Nurse's Note dated 7/4/2021 at 7:16 pm states, "Incident Note Text: resident (R4) found on floor in room skin tear on left elbow denies other injuries denies hitting head states was trying to go to bathroom." The Post Fall Evaluation Note dated 7/4/2021 at 7:25 pm documents "Fall was not witnessed. Fall occurred in the Resident's room. Resident was attempting to self-toilet at time of the fall." The Evaluation documents "(R4) was sitting out in common area next to nurse's desk but needed to use the restroom, so resident got up with walker and walked to (R4's) bedroom. Staff heard resident fall. Staff went to resident's room and found resident on the floor" and "Resident states (R4) was coming out of bathroom and lost balance." The Evaluation documents R4 suffered a skin tear and complained of left elbow pain. The Evaluation documents an alarm was not sounding when R4 was found. The Fall Report dated 7/4/21 and the Post Fall Evaluation Note dated 7/4/21 do not document when R4 was last toileted or received incontinence care prior to the fall. The Late Entry Fall Follow Up Note dated 7/4/21 documents "(R4) started c/o (complain of) pain left elbow, bruising and swelling noted. X-ray performed (on 7/6/21) and found to have fx (fracture)." The X-ray Report dated 7/6/21 documents R4 has a transverse olecranon (bony prominence of the elbow) fracture of R4's left elbow.	S9999		

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S9999	Continued From page 16 The Nurses Note dated 7/9/21 documents R4 had a cast placed for the left elbow fracture. On 9/14/21 at 10:00 am V24 (RN) stated when R4 fell on 7/4/21, R4 broke R4's arm. V24 stated R4 fell in R4's room. V24 stated R4 would not stay in the chair or call for help. V24 stated the CNA staff found R4 on the floor and alerted V24. V24 stated initially R4 complained of left arm pain and then after they assisted R4 off the floor, R4 stated R4 had no pain. V24 stated over the next few days R4 complained of arm pain and was not using R4's arm, so a portable x-ray was obtained which indicated R4 had a fractured arm. V24 stated V24 was not aware R4 should have had a motion sensor in R4's room. V24 stated no alarm was sounding to alert staff R4 was up in R4's room. V24 stated R4 could propel R4's self quickly in the wheelchair, and R4 would go to R4's room. V22's (LPN) Nurse's Note dated 9/5/21 documents "observed (R4) sitting on the floor by nightstand; noted hematoma right forehead and two skin tears left thumb; movement of all ext (extremities) WNL (within normal limits); skin tears on thumb cleansed et (and) bandage applied; Ice pack to hematoma." The Post Fall Evaluation dated 9/5/21 states on 9/5/21 R4 fell in R4's room. The Evaluation documents no alarm was sounding. The Fall Report dated 9/5/21 documents the root cause of R4's fall was that R4 was attempting to transfer and ambulate without staff assist. The Fall Report dated 9/5/21 does not document an alarm was sounding when R4 was found on the floor.	S9999		

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S9999	Continued From page 17 On 9/14/21 at 9:30 am V22 (LPN) stated on 9/5/21 R4 got up out of bed and was found sitting on the floor leaning on the night table. V22 stated R4's roommate (R25) turned on the call light to alert staff that R4 had fallen. V22 stated R4 suffered a hematoma to R4's forehead when R4 fell. V22 stated R4 frequently gets up by R4's self. V22 stated an alarm was not in use when R4 fell on 9/5/21. On 9/13/21 at 2:40 PM R4 was seated in a wheelchair at the nurse's station with a cast on R4's left arm and bruises to R4's right forehead and cheek. On 9/15/21 at 11:25 am V3 (Assistant Director of Nursing/ADON) stated residents should be toileted upon rising, before and after meals and at bedtime. V3 confirmed R4's 7/4/21 fall investigation and medical record do not document when R4 was toileted or received incontinence care on 7/4/21. V3 stated the nurses should include this information in their documentation. On 9/14/21 at 10:45 am V3 (ADON) stated if R4 is taking R4's self back to R4's room, the motion sensor alarm should be on in R4's room at all times. V3 stated the intervention for R4 to have a motion sensor in R4's room to alert staff when R4 is up was implemented in April 2021. V3 confirmed R4 should have had the motion sensor on in R4's room when R4 fell on 7/1/21, 7/4/21 and 9/5/21. On 9/14/21 at 10:45 am R4's room was observed with V3. At that time no motion sensor was present in R4's room. V3 stated the motion sensor box should be on R4's night table and the alarm box should be at the nurses station. V3	S9999		

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S9999	Continued From page 18 located the motion sensor box and alarm box at the nurse's station. On 9/14/21 at 1:15 PM V8 (LPN/R4's nurse) stated V8 did not know R4 was supposed to have a motion sensor alarm in R4's room. On 9/14/21 at 1:30 pm V19 (Nurse Practitioner) stated R4 has had multiple falls at the facility, and R4 fractured R4's arm during one of the falls. V19 stated R4 has cognitive impairment and tries to get up independently. V19 stated V19 would expect facility staff to have interventions in place to prevent falls. 3. R5's Admission Record dated 9/14/21 documents R5 admitted to the facility on 6/10/21 with diagnoses including Cerebral Infarction, Dementia, and Hemiparesis and Hemiplegia of right dominant side. R5's MDS dated 7/30/21 documents R5 has severe cognitive impairment and requires extensive assistance of one staff person for transfers. R5's Care Plan revised on 6/29/21 documents R5 is at risk for falls. R5's care plan includes interventions to ensure call light is within reach, encourage participation in activities, ensure appropriate footwear is worn, physical therapy to evaluate and treat, ensure items are within reach, and follow the facility's fall protocol. There are no documented post fall interventions after 6/29/21. R5's Fall Report dated 8/20/21 at 3:45 AM documents: R5 was found lying on the floor without injuries, and R5 stated R5 needed to use the bathroom. R5's Fall Report dated 8/26/21 at 4:00 PM documents R5 was heard yelling for help	S9999		

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S9999	Continued From page 19 and was found in an unidentified resident room lying on R5's left side. R5 had a 2 cm (centimeter) by 0.2 cm laceration above R5's left eyebrow, and 2 cm by 2 cm scrape to R5's left knee. R5's Post Fall Worksheet dated 8/26/21 documents an intervention to "add chair alarm." R5's Nursing Note dated 9/10/21 at 5:53 AM documents R5's roommate notified staff that R5 was on the floor. R5 was sitting in front of the bed. R5 had an abrasion to R5's right lower back. There is no documentation that an alarm was in use or sounding at the time of R5's fall. There is no documentation that a post fall investigation was completed to identify the root cause of R5's falls or that post fall interventions were implemented. There are no documented post fall neurological assessments completed for R5 after 9/10/21 at 9:45 AM. On 9/13/21 at 1:46 PM R5 was sitting in a wheelchair in the dining room. There was no alarm observed on R5's wheelchair. On 9/13/21 at 3:39 PM V25 (Human Resources) was pushing R5 in a wheelchair onto R5's unit. R5's wheelchair did not contain an alarm. On 9/13/21 at 2:38 PM V14 (CNA) stated R5 does not utilize an alarming device in the wheelchair or bed. On 9/13/21 at 2:17 PM V3 (ADON) stated: V3 is responsible for completing post fall investigations and updating the care plan with post fall interventions. V3 has not completed post fall investigations for R5's falls on 8/20/21, 8/26/21, and 9/10/21. V3 confirmed R5's care plan has not been updated with post fall interventions for R5's falls. After R5's fall on 8/26/21, V26 (LPN) requested an alarm be implemented for R5. V3 provided an alarm for R5, and R5 should have an	S9999		

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alarm in the bed and wheelchair. V3 stated, "On 8/20/21 R5's fall occurred around 3:00 AM, so we initiated toileting assistance scheduled between 2:30 and 3:00 AM." V3 wasn't aware of R5's fall on 9/10/21 since an incident report had not been completed for R5's fall. V3 stated, "If a fall is not witnessed, then neurological assessments must be completed according to the facility policy." V3 confirmed that R5's fall on 9/10/21 was unwitnessed.

On 9/13/21 at 3:29 PM V1 (Administrator) provided R5's neurological assessment flow sheet for R5's fall on 9/10/21. V1 confirmed the flow sheet does not document neurological assessments were completed after 9/10/21 at 9:45 AM.

The facility's undated Fall Prevention policy documents: "It is the policy to provide each resident with an appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. Additionally, all resident falls in this facility are analyzed and trended through the QA (Quality Assurance) process to maintain a safe environment." "Clinically appropriate interventions will be put into place to reduce the risk for falls and/or to prevent recurrence of falls. The interdisciplinary team will review and modify the fall risk prevention plan at a minimum of quarterly, after each fall, and as clinically indicated. Interventions for the fall prevention plan will be modified following the interdisciplinary review and changes will be made to the plan of care." This policy documents neurological assessments will be completed per protocol for unwitnessed falls and documented in the medical record, incident/accident reports will be completed for tracking and trending and an investigation will be completed with a

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S9999	Continued From page 21 documented summary. The facility's undated Neurological Assessment protocol documents: "Neurological assessments should be performed as follows for a 72-hour period, unless otherwise ordered by the attending physician." This protocol documents to complete post fall neurological assessments every 15 minutes for 4 times, every hour for 4 times, every two hours for 8 times, and then every four hours until 72 hours has been completed. The facility's undated Fall Prevention policy documents, "It is the policy to provide each resident with an appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. Additionally, all resident falls in this facility are analyzed and trended through the QA (Quality Assurance) process to maintain a safe environment." "Clinically appropriate interventions will be put into place to reduce the risk for falls and/or to prevent recurrence of falls." (A)	S9999		