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S 000	Initial Comments First Annual Health Certification Revisit to 8/9/21	S 000		
S9999	Final Observations Statement of Licdnsure Violations: 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 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	S9999		

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S9999	Continued From page 2 resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on interview, observation and record review, the facility failed to provide supervision, investigate falls, and implement resident centered interventions to prevent falls for 2 of 3 residents (R22, R34) reviewed for falls in the sample of 13. The failure resulted in R22's fall sustaining an eyebrow laceration requiring 2 stitches and a nasal fracture. Findings include: 1. R22's Admission Record, print date of 9/30/21, documents R22 was admitted on 1/31/2017 with diagnoses of Parkinson's Disease and Dementia with behavioral disturbance. R22's Minimum Data Set (MDS), dated 8/25/21, documents R22 is severely cognitively impaired, requires extensive assistance of 2 staff members for bed mobility, transfers, locomotion on the unit, dressing, toileting and personal hygiene. This MDS also documents R22 requires limited assistance of one staff member for ambulation in the room and is not steady, only able to stabilize with staff assistance with all walking and position changes. This MDS further documents R22 is not on a toileting program, occasionally incontinent of bladder and is always continent of bowel. R22's Care Plan, dated 12/21/2019, "(R22) is at risk r/t (related to) Parkinson's with dementia, personal choice to remain as independent in all ADL's (Activities of Daily Living) despite poor safety choices and hx (history) of falls with need for monitoring. Interventions: Encourage (R22) to	S9999		

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S9999	Continued From page 3 remain in high traffic areas when up in wheelchair 9/21/21. Ensure residents pants and briefs are properly fitting and adjusted 9/15/21. Incontinent station in bathroom 9/19/21. (R22) is aware of all of his fall interventions and understands them, continues to refuse to follow them and wait for assistance from staff 9/20/21. Low bed 2/1/20. Nonskid slipper socks to be worn 6/3/2019. Offer toileting before and after meals 9/20/21. Place urinal at bedside 10/3/2019. POA (Power of Attorney) to bring small size pants for resident 12/20/20. PT/OT (Physical Therapy/ Occupational Therapy) to treat for falls 9/13/21. Reeducate (R22) to be patient after he rings call light for someone to answer it 9/20/19. Staff educated to check on resident more frequently while in bed 1/27/20. Staff educated to remain with resident while toileting 9/13/21." R22's Fall Risk Data Collection, dated 9/3/21, documents R22 is a high risk for falls. R22's Nurses Note, dated 9/3/21 at 6:11 PM, documents, "At 4:30 PM writer walked into resident's room to see roommate, when writer turned around Resident sitting on the floor. Fully dressed with tennis shoes on and a comb in hand. Resident denied hitting head and denied having any pain. CNA (Certified Nurse Assistant) and writer assisted resident into a standing position where skin was assessed with no new areas of impaired skin integrity, and then into wheelchair." R22's Medical Record does not have a fall investigation or a new intervention to prevent falls for R22's fall on 9/3/21 at 4:30 PM. R22's Nurses Note, dated 9/3/21 at 11:23 PM, documents, "At roughly 6:37 PM writer heard	S9999		

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kitchen staff request help in the dining room. Upon approaching, writer observed resident standing in front of wheelchair with a reddened area to right forearm-resident sat down in wheelchair at this time. Writer asked what had happened, kitchen staff stated resident was adjusting in chair, staff looked away and then saw R22 stand and fall to the ground (was not completely aware if resident hit head), resident then stood back up on own. While first set of vitals were being obtained, resident stated was trying to go to room when questioned by writer. No signs of incontinence, wearing well fitted clothes and gripper socks. Assessment of resident: AOx2 (Alert and Orientated x 2), 5.1 cm (centimeter) x 0.6 cm abrasion observed to right outer forearm, answers question with no difficulty/appropriately. Environment of dining room: quiet, well lit with no obstacles on floor/dry floor. Upon request of resident, resident was taken back to room- transferred to bed with unsteady gait, one assist and continued to deny pain and or discomfort. Fall huddle performed at this time; reeducated resident regarding asking for assistance/call light usage. Treatment order for skin impairment charted as followed: cleanse abrasion to right outer forearm with wound cleanser, apply TAO (triple antibiotic ointment) and leave OTA (open to air)."

R22's Medical Record does not have a fall investigation or a new intervention to prevent falls for R22's fall on 9/3/21 at 6:37 PM available for review.

R22's Health Status Note, dated 9/13/21 at 4:15 AM, documents, "Resident was sitting on the toilet and attempted to ambulate and fell hitting head on the wall. Resident has a slight red area to mid forehead. No c/o (complaint of)

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S9999	Continued From page 5 discomfort." R22's Fall Investigation, dated 9/13/21, documents, "Conclusion: CNA took helped resident to the toilet and then left to go and throw away a used incontinent brief. Upon interview with CNA, he had taken resident to the bathroom and went outside bathroom door to throw away incontinent brief in the trash can. He had maintained visual site of (R22) and saw leaning forward and ran to R22 but before he could get to (R22) fell, intervention at this time staff education was provided." R22's Nurses Note, dated 9/15/21 at 7:30 AM, documents, "Writer was across the hall from resident's room and observed resident walking across room toward the doorway. Gait was very unsteady and was swaying. Pants were halfway down. Writer quickly approached resident to assist , but before writer reached resident R22 grabbed on to the door knob and lowered self onto buttocks on the floor. Resident did not hit head. Writer assessed resident for pain/injuries. Resident denies pain, no injuries noted. Resident was not incontinent. Writer asked resident, "were you trying to use the toilet?" to which replied "no." Writer asked (R22) what he needed/why he was up by himself but was unable to give writer an answer." R22's Fall Investigation, dated 9/15/21, documents, "Conclusion: Upon investigation (R22) was noted by nurse to be walking across room with pants down toward the doorway she went to assist and as she did, resident grabbed the door knob and lowered self to the floor. Pants and briefs were loose fitting and falling down as resident walked interventions is to ensure pants and briefs are secure and properly fitting." R22's	S9999		

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S9999	Continued From page 6 Care Plan intervention dated 12/20/20 documents for POA to bring size small pants, so the issue of ill-fitting clothing had been an issue before. R22's Situational Assessment Background Recommendation (SBAR), dated 9/19/21, documents, "The resident is experiencing a change in condition. See SBAR assessment for further information and family/physician notification. The change in condition the resident is currently experiencing is Resident fell and has bruising to nose, abrasion to left eye brow and back of right head. CNA stated that she put resident on the toilet and walked out of the bathroom to get a new incontinent brief. When CNA walked back in room resident laying on the floor. Other CNA came and got writer. Resident noted to have blood on the back of his head, blood on the floor. Resident alert and said that nose hurt. Resident able to move extremities. Assisted up in wheelchair and neuros (neurological check) initiated." R22's Nurses Note, dated 9/19/21, documents, "At approximately 3:05 PM Writer called into room and resident laying on the floor in the bathroom. Cut noted to the back of resident's head on the right side. Blood on face. Open area noted to left eye brow and a nose bleed. Writer talked with resident and resident able to respond appropriately. ROM (range of motion) with no discomfort. CNAs able to assist resident into a standing position and put into wheelchair. Resident said that fell forward off of the toilet. Writer called POA at approximately 3:10 PM, MD (medical doctor) gave order to send to ER (Emergency Room) at 3:12 PM, Report called into local ER. Ambulance here to transport resident to the ER at 3:40 PM."	S9999		

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R22's Nurse Note, dated 9/19/21, documents, "ER called and said that resident received a tetanus shot, sutures to eyebrows, CT (Computed Tomography) of head neck and shoulders. Resident does have a nasal (fracture) Primary MD will have to decide if wants resident to go to an ENT (Ear Nose and Throat Doctor)."

R22's Fall Investigation, dated 9/19/21, documents, "Upon investigation it was noted by CNA that resident was ambulating unassisted to the bathroom. She noted that brief was wet and needed changed. She did not have a brief and has to retrieve one that was within close proximity. During this few second time frame, (R22) attempted to transfer self and fell. Resident was sent to local hospital for evaluation and was noted to have a nasal fracture and required sutures to close laceration to left eyebrow. Care plan was reviewed and updated with new interventions for PT to eval for positioning when on toilet, staff to offer and assist with toileting before and after meals. We have also placed an incontinent station in h bathroom to ensure all supplies are ready when in the bathroom."

R22's Hospital Record, dated 9/19/21, documents, "CT Report Findings: Bones: Bilateral nasal bone fractures, commuted on the right, with lateral displacement of the bilateral nasal bone fragment, up to 3 millimeters on the right. No additional fractures." This hospital Record also documents, "Procedures: The location of the laceration was the left (side) left supraorbital. The length of the laceration repair was 2 centimeters. There were 2 sutures placed."

R22's Nurses Note, dated 9/21/21, documents, "At approximately 830 AM, after hearing a thud as I was down the hall patient was found on floor

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S9999	Continued From page 8 lying on right side with shoulder back facing bathroom door with legs extended by this nurse, floor mat in place and lower extremities on mat wear only a incontinent brief. Head resting on floor. patient assessed. ROM wnl (within normal limits) for this patient, denied pain. answered yes when asked if he felt okay. neuro assessment completed, WNL for this patient. assisted to standing position with CNA and gait belt, patient stood upright, positioned sitting up in wheelchair. bedside table sat in front at doorway so visual observation could be maintained from hallway. call light clipped to WC (wheelchair). grippy socks put on. education provided to patient on use of call light and to not get up on own r/t (related to) safety concerns. neurochecks in place. VSS (vital signs stable). no s/s (signs and symptoms) of distress. denied pain at this time. finished breakfast, ate 100%. CNAs assisted back to bed at approximately 930 am. reports was resting peacefully. at approximately 10 am this nurse went in to re-assess patient post fall. patient noted to be grimacing, moaning slightly with pain during assessment. right shoulder protruding forward. ROM assessed and grimacing continues, fisted and jaw clenched, appeared shoulder may have been dislocated. discoloration to L (left) foot that appears green and purple from prior incident DON (Director of Nurses) notified. staff reports patient has frequent shoulder dislocations; diagnosis report confirms chronic injury. call placed to MD office, new orders to send to ER received. call placed to 911 services for EMS(Emergency Medical Services) transfer. call placed to (local hospital) reported patient status to floor nurse in ER. at approximately 1 PM ER nurse calls facility to inform us they were sending patient back, that he has chronic dislocation and that it does not return to place. no new fractures noted to right shoulder	S9999		

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or foot. EMS drops patient off at facility at apx (approximately) 130 PM. VSS 98.2 - 60 - 18 - 157/87 - 98% ra (room air). c/o right shoulder pain at 5-6/10. new orders from ER for naproxen."

R22's Fall Investigation, dated 9/19/21, documents, "Conclusion: Resident was found laying on right side with back against his bathroom door. (R22) is aware of fall precautions but chooses not to follow them. Staff will encourage (R22) to remain in high traffic area when up in wheelchair."

R22's Nurses Note, dated 9/23/21, documents, "I&A (Incident and Accident) with neuros continues. Bruising noted left cheek, nose swollen , denies any complains, denies any complaints of discomfort at this time."

On 9/30/21 at 10:28 AM, V27, Regional Nurse Consultant, stated, "That on the fall of 9/19/21 the aide just went outside the bathroom to the half closet right outside room in the hallway. R22 is very impulsive and will get up as you are telling him not to." V3 further agreed that R22 does have Dementia and the aide was not able to see R22 while she was in hallway.

On 9/30/21 at 12:34 PM, V28, Therapy Director, stated, "(R22) originally came off of therapy in May and then went on a maintenance program. This is where we see him once a week for balance and eating. On 9/16/21 we picked him back up for PT and increased his OT. Falls increased when R22 has a room changes, which unfortunately with COVID, it happens."

On 9/30/21 at 12:36 PM, V29, Certified Occupational Therapy Assistant (COTA), stated,

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"(R22) is having a as the Doctor calls it a natural response progression related to his Parkinson's. R22 has episode, it is almost like a seizure. R22 does have good sitting balance but is very impulsive and with involuntary muscles movements, is not safe to be left alone sitting on the toilet."

On 9/30/21 at 10:00 AM, R22's bathroom was observed. R22's incontinent station only had wash cloths in it.

On 10/4/21 at 11:17 AM, V2, Director of Nurses, stated that she does not have a fall investigation for both R22's falls on 9/3/21. V2 stated that she did not find out about R22's falls on 9/3/21 until later after it had happened. V2 did state that she expects staff to not leave R22 on the toilet alone and that she realizes R22 being educated is not a progressive intervention since R22 is severely cognitively intact and very impulsive.

2. R34's Admission Record, print date of 10/4/21, documents R34 was admitted 7/24/21 with diagnoses of repeated falls and symptoms and signs involving cognitive.

R34's MDS, dated 7/28/21, documents R34 is moderately impaired and requires extensive assist of 2 staff members for bed mobility and transfer. This MDS also documents R34 is not steady, only able to stabilize with staff assistance with all walking and position changes and has range of motion impairments on one side of both the upper and lower extremities.

R34's Nurses Note, dated 9/9/21, documents, "patient was witnessed sliding from bed to floor in room. CNA was unable to reach in time. patient hit elbow on bed frame in process and caused

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skin tear. upon assessment patient was sitting upright against bed frame with legs fully extended. cognition status WNL for this patient. neurochecks wnl. no pain upon palpitation of back and neck."

R34's Medical Record does not have a fall investigation or a new intervention to prevent falls for R34's fall on 9/9/21.

On 9/29/21 at 9:40 AM, V10 CNA, stated, "(R22 and R34) are both very high risk for falls and are very monitored to prevent falls."

On 10/4/21 at 11:17 AM, V2, Director of Nurses, stated that she does not have a fall investigation R34's fall on 9/9/21. V2 stated that the nurse documented R34's fall in the wrong place so she did not know about the fall.

The facility Fall Policy, dated 9/17/19, documents, "Policy: The facility shall ensure that a Fall Management Program will be maintained to reduce the incidence of falls and risk of injury to the resident and promote independence and safety." It continues, "Following any falls, the facility staff completes an Occurrence Report. Details of the fall will be recorded, and potential causal factors identified and investigated. Interventions will be implemented, and Care Plan updated. Fall patterns and trends should be discussed and recorded in the Quality Assurance minutes to enhance the success of the program."

" B "