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	IL6010078	A. BUILDING: _____ B. WING _____	11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE OASIS	16000 SOUTH WABASH SOUTH HOLLAND, IL 60473

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S 000	Initial Comments Annual Certification and Licensure Complaint 2197963/IL139663 Complaint 2198129/IL139971 Complaint 2198327/IL140119	S 000		
S9999	Final Observations Statement of Licensure Violations: Finding 1 of 2: 300.610a) 300.1210 b) 300.1220 b)2) 300.3240 a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to keep a resident free from abuse by allowing staff ,V27 (Certified Nurse Assistant), to continue providing direct care to a resident who previously made allegations of abuse against the staff member. This failure applied to one of one (R1) resident reviewed for abuse and resulted in R1 experiencing continued emotional and mental anguish. Findings include:	S9999		

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S9999	Continued From page 2	S9999		

R1 is a 69 year old originally admitted on 7-21-2021 with medical diagnosis that include and are not limited to: diabetes, hypertension and lack of coordination. R1's medical records reads: R1 is alert and oriented X3, with Brief Interview for mental status (BIMS) score of 15, which means intact cognition.

On 11/21/21 11:05 AM R1 was observed sitting in wheelchair, clean, dressed and in no apparent distress. R1 is watching television and is eager to speak with Surveyor upon introduction. R1 became tearful while expressing concerns regarding one staff member, V27 (CNA).

On 11/21/2021 at 11:05 AM, R1 said " I have reported verbal abuse regarding V27 (CNA). I reported it to the Director of Nursing that was here, and the Social Worker. V27 (CNA) would say something forceful and slam my door. I suffered physical abuse at another nursing home before coming here. I feel like V27 (CNA) just taunts me and does things just to mess with me. Sometimes V27 (CNA) is on the phone and talking to others while providing care to me. V27 (CNA) gets me up in the sit to stand machine to wash me up and doesn't put lotion or cream on me. I have raw, pink skin on my bottom, but no sores. V27 (CNA) won't come and help me, and it makes me sad and makes me want to try harder to get out of here. I pray I can get out of here."

On 11/23/21 11:05 AM R1 stated V27 (CNA) didn't want to change R1 when R1 asked to be changed. This resulted in urine leaking through incontinence brief, saturating the wheelchair and leaking onto the floor. R1 said that V27 (CNA) was accusing R1 of purposely spilling water in R1's lap to make it appear that urine was on the

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S9999	Continued From page 3	S9999		

floor. R1 told V12, Nurse, that this happens all the time and that V27 (CNA) lies about R1.

On 11/23/21 at 11:30 AM , R1 is observed in room with V27 (CNA) and V12 (LPN), receiving incontinence care. V27 (CNA) left the room when Surveyor entered. Resident is visibly upset expressing concerns to V12 , Nurse, regarding V27 (CNA). R1 said "I don't want V27 taking care of me! I keep telling you all and nobody listens to me!"

At 11:35AM, V12, Licensed Practical Nurse (LPN), said "I wasn't aware that there was any issue with V27 (CNA) and R1. I came in because V27 (CNA) said that R1 was upset while V27 (CNA) was providing care."
At 11/23/21 11:37 AM ,V27 (CNA) said "I take care of (R1) Monday through Friday. When I do take care of her, I try to have someone else with me, because I have had problems with her saying that I'm doing all kinds of stuff to her. I had a conversation with V1 (Administrator), and she gave me a choice to have someone go in with me, or find someone else to switch R1 with. V1 told me that I had to ask another (CNA) to take care of her on days that I worked. I last changed R1 2 hours ago, but I did not document that. V32 (CNA) helped me."

At 11:45 AM, V32 (CNA) said "I am helping with R1 to get cleaned up now, but I have not been in R1's room today, prior to this time."

At 12:10 PM on 11/23/2021, V2, Acting Director of Nursing (DON), stated if a resident alleges abuse towards staff, it depends on the results of the investigation whether the staff would continue to care for that resident in the future. If the Resident complains, the resident says they are not safe or

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S9999	Continued From page 4 don't want that staff anymore they absolutely should not care for the resident again. On 11/23/21 01:50 PM, V1 (Administrator) said "R1 reported to the past Director Of Nursing that there was an issue with V27 (CNA). As a result, V27 (CNA) was given a verbal disciplinary action which was documented on paper. One of the concerns was that V27 (CNA) wouldn't come prepared to care for R1with all the necessary care items and R1 felt as if R1 was waiting for long periods of time. V27 (CNA) would keep going in and out of the room to get things and left R1 half-dressed or exposed during care. That was the last time R1 expressed any issues, which was in October of this year. I am the abuse coordinator. The staff know to talk to me regarding any allegations of abuse." V1 (Administrator) stated on 10/8/2021, "V27 (CNA) was given a "teachable moment" which is a sort of disciplinary write up. At the time, I did not consider the behavior of the V27 (CNA) as being abusive, I considered it being rude. R1 claimed that V27 (CNA) came into the room and demand that R1 get up and get dressed. It was explained to V27 (CNA) that we cannot demand anything from the residents because this is their home. If the residents decide they don't want to get up on a particular day that is their right. V27 (CNA) was written up for being rude to R1 but I didn't consider it to be abuse. The disciplinary action taken was the write up according to the union and the union employee conduct policy." On 11/23/2021 at 2:40PM V28 (LPN) said "V12 has left for the day, so I am taking care of all the residents on the 100 and 200 unit until the next shift comes in. I wasn't aware of any staff that wasn't able to work with R1. I don't usually take	S9999		

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S9999	Continued From page 5 care of R1, so I wouldn't know. The Director of Nursing, Assistant Director of Nursing or the Administrator would be the ones to let the nursing staff know if a CNA wouldn't be able to take care of a resident because the nurses are responsible for making the CNA assignment every shift." On 11/23/2021 at 2:45PM V3 (Care Plan Coordinator) said " I am not aware of any allegations of abuse from R1. I don't have an abuse care plan in place for R1." On 11/23/2021 at 3:25 PM V7 (Social Worker) said " I knew about the allegation regarding R1. I did a Screening assessment for Aggressive or Harmful Behaviors during the quarterly review this month and did not determine that R1 was at risk for abuse. No additional assessment for abuse has been conducted. " In R1's facility assessment records, a Screening Assessment for Indicators of Aggressive and /or Harmful Behaviors conducted by V7 (Social Worker) dated 11/09/2021 indicated in Section D titled "Abuse/Neglect Factors" that R1 did not have a history of abuse, did not have any factors that would increase R1's vulnerability, such as weakness or poor ambulation and did not have a history of dysfunctional behaviors, such as aggressive, manipulative derogatory or disrespectful. V27 (CNA's) personnel filed reviewed, background and signs of misconduct. V27 received a "Teachable Moment" written notice which states details as "Having inappropriate conversations with residents may be considered rude or abusive". V1 (Administrator) admitted to not following up this write-up as an abuse investigation, therefore none is available. V27	S9999		

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S9999	Continued From page 6 (CNA) received an additional written disciplinary action notice signed 10/11/2021 misconduct leading to "Discourteous Behavior" which reads as follows: R1 reported V27 (CNA) as being rude to R1 stating that V27 would not get R1 up this morning because R1 does not have a chair. No progress notes were available in regard to any complaints of abuse or neglect during this survey investigation. On 11/23/2021 at 4:04PM V1 (Administrator) presented undated policy titled "Abuse Prevention Program Facility Policy" which reads in part; "The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse by: identifying occurrences and patterns of potential mistreatment, immediately protecting residents involved in identified reports of possible abuse, implementing systems to investigate all reports and allegation of mistreatment promptly and aggressively, making the necessary changes to prevent future occurrences and filing accurate and timely investigative reports". (B) Finding 2 of 2: 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	S9999		

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S9999	Continued From page 7 be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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	S9999		

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S9999	Continued From page 8 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. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to provide supervision of residents assessed as high risk for falls; failed to formulate and implement individualized and measurable care plan interventions in preventing falls and failed to follow its policy related to fall investigation for four (R1, R25, R31 and R80) of four residents in a sample of 31 reviewed for accidents and supervision. These deficiencies resulted in R31 sustaining a pubic rami fracture after a fall incident. Findings include: 1) R25 is a 107 year old, female, admitted in the facility on 05/28/21 with diagnoses of Unspecified Fall, Subsequent Encounter; Functional Quadriplegia; Alzheimer's Disease, Unspecified;	S9999		

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S9999	Continued From page 9 Unspecified Lack of Coordination; Weakness and Age-Related Physical Debility. The following fall incident reports documented: 11/01/21 R25 was noted to be lying on the floor on right side wrapped in blanket. Small skin tear to right shoulder was noted. There were no other apparent injuries noted. R25 was sent to the hospital for further evaluation and treatment. 10/08/21 R25 was observed on the floor on left side next to her bed awake and alert wrapped in blankets. R25 could not recall what happened. Head to toe assessment completed. Alert and responsive. Denies hitting head. Verbally responsive. No signs and symptoms of pain were reported and no injuries noted. Sent to the hospital for evaluation and treatment. 08/16/21 -R25 was noted lying on right side on the floor wrapped in bedding, with head resting on right hand and arm. There were no injuries observed at the time of incident. Sent to the hospital for further evaluation and treatment. On 11/22/21 at 10:12 AM, R25 was observed in bed, asleep but can be awakened through verbal and tactile stimuli. R25 is able to talk, shakes head for a yes or no answer but unable to engage in a conversation. Bed in the lowest position and a fall mat was placed on the right side of bed. The head of bed was positioned at 30 to 45 degrees angle with body in a slight diagonal position with head leaning on the left side. A pillow was placed under lower extremities. On a low air loss mattress. The mattress is covered with a top white sheet. There was a disposable incontinent pad underneath R25's back. At 12:42 PM, V8 (Certified Nurse Assistant, CNA) was observed feeding R25 while in bed. During feeding, V8 elevated the head of (R25) bed at a 70 to 75 degrees angle. After (R25) finished eating meals,	S9999		

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S9999	Continued From page 10 V8 placed back the fall mat on the left side of (R25) bed, took the food tray and left the room. On 11/23/21 at 10:56 AM, V13 (Minimum Data Set, MDS Coordinator) was interviewed regarding R25's fall incidents. V13 stated, "On 10/08/21, yes, R25 had a fall. I was the floor nurse that day. R25 was on the floor by bed wrapped in blanket. Head to toe assessment done, no injuries but was sent out for further evaluation. When R25 had the fall on 10/08/21, maybe R25 attempted to roll and fell out of bed. Interventions that need to be implemented are the use of floor mats, more frequent rounds ensuring is positioned in the middle of the bed. When R25 was found that time, the bed was in lowest position, the head part of the bed was like 30-45 degrees. Was found wrapped with a flat sheet and the comforter." V3 (Care Plan Nurse) was also asked on 11/23/21 at 11:09 AM regarding R25's fall incidents. V13 verbalized, "R25 had falls on 08/16/21; 10/08/21 and 11/01/21. There were no injuries noted on those fall incidents. R25 is generally alert, 107 years old. R25 never walks, been in the chair, up in a reclining chair and assisted by staff on all transfers. The fall incidents mentioned that was found on the floor wrapped in blankets. R25 is on low bed, does have the floor mats. . R25 can move somewhat, move and position self.. As R25 was trying to reposition can make her roll, unaware of position on bed and be close to the edge and fall out of bed. R25 should be monitored for positioning while in bed, make sure R25 is at the center of the bed; needs to be frequently repositioned every one to two hours, make sure R25 is not entangled in a blanket; and bed should be in the lowest position with the head of the bed up around 30 degrees."	S9999		

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S9999	Continued From page 11 According to R25's fall care plan with revision date of 10/15/21, the following interventions were documented: 10/8/21: Staff to ensure resident does not have too many blankets in bed while resting 10/8/21: Resident up during morning (7-3) shift and back down for 3-11 shift 08/16/21: Educate resident to use call light and call for assistance as needed 11/09/21: Ensure resident's bed is not left in upright position while in bed 11/09/21: Place resident in geri-chair (reclining chair) for meals 06/02/21: Be sure call light is within reach and encourage the resident to use it for assistance as needed. Staff to respond promptly to all requests for assistance. On 11/23/21 at 2:10 PM, V10 (Nurse Practitioner) was interviewed regarding her expectations on staff in fall prevention for R25. V10 replied, "The bed should be in the lowest position, there should be floor mats at bedside and frequent rounding - at least see (R25) every hour, either CNA, nurse or staff member, by at least walking by the room to look at her. To physically see that she is not on the floor. She cannot be educated in calling for assistance or use the call light because she is not able to retain that information or recall. She is not able to demonstrate the use of call light." Per R25's MDS dated 09/03/21, R25's BIMS (Brief Interview for Mental Status) score was 3 which means severe cognitive impairment. 2) R80 is a 77 year old, initially admitted in the facility on 04/20/21 with diagnoses of Unspecified Fracture of Left Femur, Subsequent Encounter	S9999		

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S9999	Continued From page 12 for Closed Fracture with Routine Healing; Repeated Falls; Other Specified Disorders of Bone Density and Structure, Unspecified Site and Unsteadiness on Feet. R80's progress notes documented: 11/22/21 - observed R80 on floor in bathroom on back with head up against the wall. R80 denied any pain but states did hit his head. Sustained an abrasion on top of coccyx area, cleansed and band aid applied. Was sent to the hospital for further evaluation and treatment. 11/23 at 4:02 AM - returned to facility. No new orders. 72 hours neuro checks in progress. Will continue to follow plan of care. 11/10/21 at 11:00 PM - observed sitting on floor, no injuries noted, no pain. 11/09/21 at 3:05 PM - nurse walking past resident's room and heard resident yell out and discovered R80 on floor on left side with hand/arm curled under head. On 11/22/21 at 10:00 AM, R80 was observed in room, in bed. R80 is alert, verbal but confusion was noted during conversation. R80 talks about his previous occupation and suddenly jumps into a different topic about friends. R80 stated can go to the bathroom alone, and does not need staff assistance. On 11/23/21, V3 was asked regarding R80. V3 stated, "R80 appears very alert, can tell you what (R80) wants to do, what R80 wants to eat, talks about past very well. But R80 is very resistive to people at times. R80 is alert, oriented to person, able to use the call light. Sometimes R80 yells if he wants something. But a lot of times, does not want to use the call light. His BIMS score was 3, which means cognitively impaired. With BIMS score of 3, probably not able to remember things.	S9999		

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	IL6010078	A. BUILDING: _____ B. WING _____	11/24/2021

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PRAIRIE OASIS	16000 SOUTH WABASH SOUTH HOLLAND, IL 60473

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S9999	Continued From page 13 Of the 4 fall incidents, R80 was trying to go to the bathroom independently not asking for any assistance. R80 does have weak legs, can walk but with assistance. Unaware of safety issues, R80 is impulsive." According to R80's fall care plan dated 10/20/21, the following interventions were documented: 10/31/21: Continue to ask resident to call for assistance 11/23/21: Continue to encourage resident to call for assist with toileting during rounds at night, assist to toilet during rounds 08/11/21: Remind R80 to ask for assistance when needed 07/22/21: Encourage R80 to call for assistance with all transfers Per R80's MDS dated 09/10/21, he has a BIMS score of 3 which means severe cognitive impairment. Facility's policy titled, "Fall Prevention Program" dated 2/28/14 stated in part but not limited to the following: Policy: It is the policy of this facility to have a Fall Prevention Program to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the program to assure ongoing effectiveness. 3) On 11/22/21 at 11:12 AM, V5 CNA (Certified Nurse Assistant) was interviewed regarding R31's fall. V5 stated, "I was the aide for day shift on 8/20/21. I saw R31's thumb was black and blue	S9999		

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S9999	Continued From page 14	S9999		

in the morning. I went to get V6, LPN. R31 told me and V6, she fell and went back to bed. R31 was limping when I tried to put her in the wheelchair. She gets up out of her wheelchair and wanders in her room, going through her closet. She wanders from unit to unit. We try to keep her at the nurses' station."
V5, CNA was asked if R31 is mentally capable of using her call light? V5 stated, "R31 was not able to use her call light. R31 has her call light pinned to her night gown during the night, but she's smart. She will take off the night gown. I've never seen her pull her call light."

At 12:06 PM, R31 seen self-propelling wheelchair through the dining room. No fall prevention devices noted on wheelchair. R31 redirected back to h table a few times by staff , noted continuously rolling around.
Upon R31's room observation, there were no fall prevention devices noted on bed or on the sides of the bed.

At 12:45 PM, V6 LPN (Licensed Practical Nurse) was interviewed regarding R31's fall. V6 stated, "R31 told me and demonstrated how she fell, she comes and goes. R31 self-propels in her wheelchair. She walks unassisted sometimes and we redirect her back to her chair. She has fallen before. We do rounds, keep bed in lowest position, and redirect her when she is up unassisted. She started favoring her hip that morning, so I sent her out."
V6 LPN was asked if R31 is mentally capable of using her call light? V6 stated, "I can't recall ever answering R31's call light. I don't think she can purposely use it. She doesn't have the wherewithal."

Review of the facility incident report indicates: On

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S9999	Continued From page 15 8/20/21, R31 walks and transfers independently. R31 reported to a CNA she fell forward, tried to catch herself using both hands during the night (8/19/21). R31 complained of left wrist pain, left hip and left knee. R31 was sent to the hospital, public guardian notified. The roommate stated she did not hear or see R31 fall. The facility falls list states: R31's last fall was 4/13/2020 with a fracture to finger of left hand. R31's current falls were 8/20/21 and 11/7/21. The care plan dated 6/10/21 indicates: R31 is at risk for falls related to unsteady gait. R31 may be unaware of safety limits due to diagnosis of Dementia and medication usage including antipsychotic medication. Goal: I will have a safe environment maintained thru the next review. Target date 12/19/21. Interventions include: Encourage R31 to call/wait for assistance when she wants to use the bathroom (3/25/20). Gather information on past falls and attempt to determine the root cause of the fall(s). Anticipate and intervene to prevent recurrence (10/28/19). Anticipate and meet individual needs of the resident (10/28/19). The current care plan dated 9/20/21 indicates: R31 had an actual unwitnessed fall in her room and sustained a fracture of the pelvis. Date initiated (8/20/21). Interventions include: Remind resident to ask for assistance when needed. Frequent monitoring. Date initiated (8/23/21). There is no documentation of staff responsible for monitoring or how often the frequent monitoring should occur. The root cause of R31's falls was not determined and individualized interventions were not implemented per facility policy.	S9999		

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S9999	Continued From page 16 The MDS Minimum Data Set (Comprehensive Assessment) dated 6/10/21 indicates a BIMS (brief interview for mental status) score of 3. A score of 0-3 indicates the resident has severe cognitive impairment. R31's 6/10/21 fall risk review indicates: 1-2 falls in last 6 months, high risk for falls. The 6/10/21 MDS Section G for Functional Status indicates: B. Transfer- how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position. 1. Self Performance= Limited assistance. 2. Support= one person physical assist. C. Walk in room- how resident walks between locations in his/her room. 1. Self Performance= Supervision. 2. Support= one person physical assist. There were no fall prevention devices in place at the time of the fall on 8/20/21. R31 was not on the falling star program due to not having a fall since 3/25/2020. On 11/23/21 at 1:03 PM, V3, Care Plan Coordinator, was interviewed regarding R31's care plan interventions and fall prevention devices. V3 stated, "Interventions are updated to the care plan as soon as they have a fall. The DON (Director of Nursing) is responsible for the fall coordination, I just update the care plans. R31's BIMS (brief interview for mental status) score is 3 which means she is cognitively impaired. V3 stated, "R31's not able to use the call light. We don't use alarms in this building." At 2:30 PM, V10, Nurse Practitioner, was interviewed regarding R31's falls. V10 stated,	S9999		

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S9999	Continued From page 17	S9999		

"R31 is alert to herself only, dependent on staff. She can self-propel her wheelchair. She can stand and walk short distances, but she is extremely unsteady on her feet. R31 has a history of stroke, impulsivity, generalized muscle weakness, osteoarthritis and dementia which all could contribute to falls. Interventions could be frequent rounding at least every hour with staff physically seeing the resident, resident being near the nurses' station and within sight. R31 has poor retention, she's unable to remember instructions. She'll be unable to retain information to use the call light."

At 2:59 PM, V2, Acting DON (Director of Nursing),was interviewed regarding R31's interventions related to falls. V2 stated, "The interventions should be determined related to the cause factor, they should be individualized, and the goals should be measurable. R31's BIMS score is low. The likelihood is she's not able to remember to use the call light."
V2 inquired of the use of fall prevention devices. V2 stated, "We use bed, chair alarms and wedges. The wedges prevent resident's from rolling out of the bed. The alarms remind and alert staff the resident is getting up, those who are impulsive and transfer themselves. The alarms will go off and give staff time to get to the residents. The devices are available, V1 (Administrator) can place an order and it can be shipped and here the next day."

Review of the 8/20/21 hospital records indicates R31 was diagnosed with a Pubic Rami Fracture.

The 2/28/14 Fall Prevention Program states: Policy: It is the policy of this facility to have a Fall Prevention Program to assure the safety of all residents in the facility, when possible. The

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S9999	Continued From page 18 program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the program to assure ongoing effectiveness. Responsibility: Director of Nurses, licensed nurses, therapists, and all facility staff. The Fall Prevention Program includes the following components: 5. Changes in interventions that were unsuccessful. 10. Care plan incorporates: a. Identification of all risk/issue. C. Preventative measures. The 6/14 Fall Prevention Alarm Devices and Systems policy states: Purpose: To establish procedures for alerting staff members of a resident's attempt to stand or get out of bed unassisted and to prevent/reduce resident falls. Equipment: Motion alarms, Pressure alarms-chair/bed, Push/pull alarms, Sound monitors, Video systems. Responsibility: All Facility Staff Policy: It is the policy of the facility to use a variety of devices and systems to promote the safety of all residents and to help prevent/reduce falls and injuries. Procedure: 2. The assessment tool will include pertinent aspects of the resident's status and pre-admission information that is available.	S9999		

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S9999	Continued From page 19 6. Safety/movement devices will be used as an integral tool to prevent unassisted ambulation and to prevent/reduce resident falls. 4) On 11/21/21 11:05 AM R1 said "I had a fall a little while ago. I was trying to get out of bed on my own because the staff left me so long in my urine and feces that I had to get up. When I went to the hospital they found I had a urinary tract infection, and I complained of right shoulder pain and my ribs hurt on the right side. I got COVID last year and it caused decreased mobility, so I can't go to the bathroom on my own. I need help when I stand to pivot." On 11/21/21 02:27 PM V29, Physical Therapy Assistant, said " R1 is not able to walk independently. I wouldn't say she could toilet without assistance. R1 should have a least one person for some physical assistance and supervision. It is not safe for R1 to toilet or ambulate independently. R1 is very cognitively aware. If R1 were to try to get up by themselves they know they may fall." 11/23/21 at 01:50 PM V1, Administrator, said " I did not instruct the nurse to create a fall report because R1 has behavioral symptoms. R1 intentionally put herself on the floor because she wanted to leave the facility. I can't say why the nurse didn't assist R1 when they witnessed R1 moving from the bed to the floor. The nurse just stated to me that R1 was angry and was smearing feces on the wall. At that time, R1 called 911 herself, and they came and took R1 to the hospital. I can't say that she has done this before. R1 was in the hospital for about 4 days and was treated for a Urinary Tract Infection. Based on my administrative experience, R1's behaviors could have been compromised due to	S9999		

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S9999	Continued From page 20 a urinary tract infection. R1 returned to the facility after the hospitalization and has not had any further incidences of falling or being on the floor. ' At 2:47PM , V13, MDS Coordinator, said "Fall assessments are conducted quarterly and whenever a fall occurs. A fall is defined as any change in plane that is unassisted." Upon record review, no Fall Investigation was conducted for R1 on 10/23/2021 and is unavailable at the time of this investigation. Fall Risk Review dated 11/17/2021 determined that R1 was "high risk" for falling. R1 Progress note dated 10/23/2021 at 7:18PM said that two nurses observed R1's bed in the highest position, and was counseled on the risk of falls. Bed was returned to the floor and R1 was re-positioned. At 7:47PM, nurse writes that while passing medication, R1 was observed in bed at the highest position, saw R1 place herself on the floor and R1 begin to yell. When R1 was questioned about being on the floor, R1 stated to the nurse, "I did not. I fell and you lying on me." It was at this time, the nurse was paged by the front desk and notified that R1 had called 911 and the ambulance was at the facility to transport. R1 was taken to a local Hospital Emergency Room for evaluation. On 10/27/2021 Nursing Progress Note written at 9:52PM said that R1 was re-admitted to the facility with a diagnosis of Urinary Tract Infection. No injuriesindicted at the time of admission. (B)	S9999		