STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008957	A. BUILDING: _____ B. WING _____	C 07/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH VILLAGE OF CHICAGO	4021 WEST BELMONT CHICAGO, IL 60641

(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 Facility Reported Incident of 6-26-22/IL00149135	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 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. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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, 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. These requirements were not met as evidenced by: Based on interview and record review the facility failed to ensure residents received adequate	S9999		

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S9999	Continued From page 2 supervision to prevent accidents for 3 (R2, R5, R38) of 6 residents reviewed for falls. This deficient practice resulted in a.) R38 having an unwitnessed fall on 06/26/22 which resulted in a Left femoral neck fracture, s/p (Status Post) hemi-arthroplasty, laceration on left occiput with staples and right elbow skin tear, b.) R5 experiencing 7 unwitnessed falls from 05/06/22 - 07/25/22 and c.) R2 experiencing a fall after being left unattended while toileting. Findings Include: R2 was admitted to the facility 08/03/16 and has diagnosis not limited to Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, Essential (Primary) Hypertension, Hypertensive Retinopathy, Bilateral, Age-Related Nuclear Cataract, Bilateral. Nonexudative Age-Related Macular Degeneration, Bilateral, Abnormal Posture, Muscle Weakness (Generalized), Unsteadiness on Feet and History of Falls. Progress notes dated 07/21/2022 document on part: Administration Note: Resident had an unwitnessed fall. CNA V9 (Certified Nurse Assistant/CNA) heard him (R2) shouting and immediately proceeded to R2's room. Found resident lying on the bathroom floor right(sic), grabbing on the hand bar. CNA called me to assess the resident prior to putting him (R2) back on the wheelchair. R2 said that he (R2) tried to go out(sic) of the toilet by himself and lost his (R2) balance. He (R2) was able to grab the hand bar and slid instead. No wound or pain on(sic) head, back and all extremities except for the half inch of skin tear on the left knee. Physician order dated 07/21/22 documents in part	S9999		

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S9999	Continued From page 3 Daily cleaning of left knee wound with NSS (Normal Saline) and apply border gauze until healed. R2's MDS (Minimum Data Set) Section C-Cognitive Patterns document in part: BIMS (Brief Interview for Mental Status) 13 indicating cognitively intact. Section G - Functional Status document in part: Toilet use; Limited assist, One-person physical assist. Section H - Bladder and Bowel: Urinary Continence; Occasionally incontinent, Bowel Continence: Always Continent. Care Plan documents in part: R2 requires supervision to extensive assist with ADL (Activities of Daily Living) care. Assist into motorized wheelchair. Toilet Use: The resident requires limited assist by staff for toileting (dated initiated 01/31/22). R2 is at risk for falls and fall related injuries due to decreased mobility. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all request for assistance, follow facility fall protocol (date initiated 01/31/22). R2's Root Cause Analysis dated 07/21/22 documents in part: Problem: Tried to transfer self to toilet, Why: Needed to use restroom, Why: Long call light and could not wait. R2's Morse Fall Scale dated 07/21/22 documents in part: Fall score of 15 indicating Low Risk 0-24. Initial Report dated 07/22/22 documents in part: On 07/21/22 at approximately 12:30, staff responded to pt. (Patient) (R2) verbal calls for assistance. Staff entered patient's bathroom and found patient on the floor beside the toilet grasping handrail. Patient stated he (R2) was attempting to transfer himself (R2) to his (R2)	S9999		

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S9999	Continued From page 4 wheelchair. Skin tear to left knee. Complaint of mild pain to the left ankle later in the day. On 07/26/22 at 10:59 AM, R2 stated "sometimes I don't feel like I am receiving proper care. I need assistant with everything, the washroom and getting dressed. Last Thursday 07/21/22 the (CNA) Certified Nurse Assistant assisted me to the bathroom. The CNA put me on the toilet and left out of the room. When I finished, I used the call light, but they did not respond, and it was uncomfortable sitting on the toilet. I have left sided weakness and can stand holding on but fell when I tried to get up off of the toilet. The nurse and the CNA came to get me up and my left knee was bleeding. I think my knee touched the wheelchair." A white bordered dressing was observed on R2 left knee dated 07/26/22. On 07/27/22 at 03:01 PM, per telephone interview V9 (Certified Nurse Assistant/CNA) stated R2 had a fall on 07/21/22. I transferred R2 to the toilet and told R2 to give me a call when he (R2) was done. R2 takes a while on the toilet so I stepped out of the room, and I went next door with the nurse. When I came out of the room, I saw the call light on and heard R2 yelling. R2 said he (R2) was trying to get himself off of the toilet. R2 was on the bathroom floor stuck between the toilet and the wheelchair. I asked why he (R2) tried to get up and he (R2) said that he (R2) did not want to sit on the toilet. I went and got the nurse, moved the chair back, got on each side of R2, put my arm under R2's arm, lifted R2 up by the pants and transferred R2 to the wheelchair. R2 had a scrape to the left knee. R2 is a one person transfer and needs help when transferring. I am not sure of the toileting policy in that facility. Usually, I stay in the room with the resident, but I went in the other room to change the 2 residents.	S9999		

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S9999	Continued From page 5 R2 is alert and able to make his (R2) needs known. R2 is not a high fall risk." On 07/28/22 at 09:35 PM, V8 (Certified Nurse Assistant/CNA) stated "R2 requires assistance to go to the bathroom, getting in the wheelchair and pulling up his (R2) pants. R2 will put on the call light when he (R2) is done in the bathroom. R2 is a fall risk because of the stroke and left side weakness." On 07/28/22 at 11:02PM, V2 (Nursing Supervisor Clinical Service) stated "I am notified if there is a fall. Everyone that enters the facility is considered a fall risk and will be assessed by the nurse. The Morse score is done after a fall. The fall risk is based on the score. Some fall interventions are individualized. R2 had a fall on 07/21/22. I am aware of the fall, and we are currently following up. R2 is a post stroke with left sided weakness. R2 is continent of bowel and bladder and is a minimum assist to and from the toilet. R2 is alert and oriented x3 with a BIMS score of 13. Based on that R2 can use the call light, make good judgement but still should have been observed while he (R2) was in the bathroom. The care plan should be updated after a fall and a review of what the staff is doing to prevent falls or injuries to that resident. If the findings of what should be done, we will implement them." On 07/28/22 at 12:25 PM, during the resident council meeting, surveyor documented R2 stated "I'm not getting the care I need, they left me (R2) too long in the bathroom on last Thursday (07/21/22). I put on the light after number two (Bowel Movement), the CNA (Certified Nurse Assistant) came to tell me (R2) and said she V9 (CNA) was with someone else and would come right back. I (R2) was in there for 20 minutes, I	S9999		

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S9999	Continued From page 6	S9999		

got up myself and fell to my knee." (R2 was observed wearing a watch). "I (R2) had a stroke on my (R2) left side and fell on the leg that I can't move". R2 denies injury, other than pain during time of incident. Survey team currently investigating this resident's complaint and incident. R37 and R13, agreed with R2 that they are left in washroom longer than they would like after pulling the call light.

On 07/28/22 V1 (Administrator) stated "The CNA stepped out of R2 room to assist another resident when R2 fell."

R5 was admitted to the facility 04/29/22 and has diagnosis not limited to Muscle Weakness (Generalized), Parkinson's Disease, Dementia with Behavioral Disturbance, Osteomyelitis and Urinary Tract Infection.

Unwitnessed report dated 05/06/22 document in part: R5 seen by wife lying on the floor. According to R5 he (R5) was trying to get up from the wheelchair going to the bed, R5 fell on his (R5) knees. Unwitnessed report dated 06/02/22 documents in part: found R5 sitting by(sic) his (R5) knees on the resident's room.

Progress note dated 05/12/22 document in part: CNA (Certified Nurse Assistant) went to resident's room to check R5 diaper then he found R5 on the floor. Resident verbalized that he (R5) was trying to get some water then he (R5) fell.

Progress notes dated 06/25/22 document in part: NOD (Nurse on Duty) heard resident (R5) shouting for help, found resident on the floor with head beside the drawer/cabinet inside his (R5) room. R5 verbalized that he (R5) was trying to fix his shoes, then he (R5) suddenly fell down.

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S9999	Continued From page 7 Progress notes dated 07/13/22 documents in part: At 12:48, CNA notified writer resident was observed on the floor. Progress notes dated 07/21/22 document in part: Resident (R5) found on the floor by side of bed in a side lying position with neck pillow under head by staff while doing rounds. Progress notes dated 07/27/22 document in part: Found resident sitting on the floor in front of his (R5) wheelchair during rounds. Resident said that he (R5) slid from his (R5) wheelchair and sat on the floor. R5's MDS (Minimum Data Set) Section C-Cognitive Patterns document in part: BIMS (Brief Interview for Mental Status) indicating resident was unable to complete the interview. Section G-Functional Status: Bed Mobility, Transfers, (Extensive Assist, Two + persons physical assist). Toilet use (Extensive Assist, One-person physical assist). R5's Root Cause Analysis dated 05/06/22 documents in part: Problem: Resident had a fall Why: Resident self-transfer, Why: Wanted to get in bed, Why: Wanted to lay down. R5 Root Cause Analysis dated 05/12/22 document in part: Problem: Resident had a fall Why: Resident self-transfer, Why: Resident attempted to get water, Why: Tried to get water without help. R5 Root Cause Analysis dated 06/02/22 document in part: Problem: Resident had a fall, Why: Tried to get out of bed, Why: Wanted to put on shoes, Why: Wanted to wear shoes and get out of the bed when he lost his balance. R5's Root Cause Analysis dated 06/25/22 document in part: Problem: Resident had a fall, Why: Tried to fix his shoe and lost his balance, Why: Didn't ask for help with shoes from CNA. R5's Root Cause	S9999		

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S9999	Continued From page 8 Analysis dated 07/13/22 document in part: Problem: Resident had a fall, Why: Appeared to have rolled out of low bed to floor, Why: Resident could not recall why. R5's Root Cause Analysis dated 07/21/22 document in part: Problem: Resident had a fall, Why: Tried to get up on his own, Why: stated he was trying to get his toast. R5's Root Cause Analysis dated 07/25/22 documents in part: Problem: Resident had a fall, Why: Slid from wheelchair to the floor, Why: Resident could not provide further details. R5's Morse Fall Scale dated 05/06/22 document in part: Fall score of 50, dated 05/12/22 Fall score of 75, dated 06/02/22 Fall score 55, dated 06/25/22 Fall score 75, dated 07/13/22 Fall score 65, dated 07/21/22 Fall score 55 and dated 07/25/22 Fall score 55. Fall Scoring: High Risk 45 and higher. Care Plan documents in part: R5 is at risk for falls r/t (Related to Gait/balance problems. Fell 05/06/22, 05/12/22, 06/02/22, 06/25/22, 07/13/22, 07/21/22 and 07/25/22 (Date initiated 05/11/22, Revision on: 07/27/22). Goal: R5 will be free of falls and fall related injury(sic) through review date (Date initiated 05/11/22, Revision on: 05/18/22, Target dated 08/08/22). Intervention/Task: Gently remind resident to call for assistance before attempting self-transfers. Keep bed in low position. (Date initiated 05/11/22). Anticipate and meet resident's needs. Ensure the resident is wearing appropriate footwear when ambulating of(sic) mobilizing in w/c (Wheelchair). (Date initiated 05/11/22, Revision on 07/27/22). Be sure the call light is within reach and encourage resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Follow facility fall protocol. Floor Mat at bedside	S9999		

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S9999	Continued From page 9 as ordered. (Date initiated 07/22/22) Avoid bedrest and inactivity. Encourage mobility and activity. (Date initiated 07/27/22). R38 was admitted to the facility on 05/10/22 and readmitted 07/06/22 with diagnosis not limited to Fracture of Unspecified Part of Neck of Left Femur, Subsequent Encounter for Closed Fracture with Routine Healing, Presence of Left Artificial Hip Joint, Muscle Weakness, Alzheimer's Disease, Dementia, Cognitive Communication Deficit, Age related Osteoporosis and History of Falls. R38 MDS (Minimum Data Set) dated 07/13/22 Section C- Cognitive Patterns documents in part: BIMS (Brief Interview for Mental Status) indicating resident was unable to complete the interview. Section G- Functional Status: Bed Mobility, Locomotion on Unit, Toilet use (Extensive Assist, One-person physical assist). Progress notes dated 05/19/2022 document in part: *Incident Note: During passing medication heard resident (R38) calling for help; upon attending to resident's room found resident attempting to get up from the floor at the doorway of resident's room door. Upon body assessment noted a 3 cm x 2 cm bump on the top of her head, no discoloration, no bleeding noted. Progress notes dated 06/24/22 document in part: Resident (R38) had an unwitnessed fall. CNA found R38 on bed holding her (R38) elbow with(sic) blood. When asked what happen (sic) R38 said that she's (R38) looking for something and R38 went out of bed then R38 fell. R38 said she (R38) immediately got back to bed. Progress notes dated 06/26/2022 document in	S9999		

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S9999	Continued From page 10 part: *Incident Note: We heard someone screaming and when we check(sic) on the resident's room R38 was lying on the floor. As I did the assessment R38 was complaining of leg pain, and I noted a laceration on the parietal area of the head about 3cm. Assessed the laceration cleanse(sic) with NSS and apply(sic) clean dressing with pressure. Doctor ordered to send out resident to the ER (Emergency Room). Progress notes dated 06/26/2022 documents in part: Health Status Note: Placed call to Medical Center, according to the ER nurse assigned to the R38, R38 will be admitted due to Close Fracture of the Left Femur. Progress note dated 07/06/22 documents in part - Clinical Admission Evaluation: Clinical Interventions: Narrative Note: Received resident from Medical Center via stretcher. There are 24 staples noted on the operative site on the left femoral area and 3 staples on the head. R38's Morse Fall Scale dated 05/19/22 documents in part: Fall score of 65, dated 06/24/22, Fall score 80, and dated 06/26/22 Fall score 70 indicating Fall scoring: High Risk 45 and Higher. Route Cause Analysis dated 06/26/22 documents in part: Problem: Resident had a fall in her (R38) room right before dinner. Why: Tried to get up to use the rest room alone. Tried to close the door and lost her (R38) balance. Why: Wanted to use the rest room. Why: Resident on water pills. Care plan document in part: R38 has impaired cognition function/dementia or impaired thought processes r/t Alzheimer's, Dementia, Difficulty making decisions, Impaired decision-making,	S9999		

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long-term memory loss, short term memory loss. (Date initiated 05/18/22). R38 is at risk for falls r/t confusion, deconditioning, gait/balance problems and unaware of safety needs. R38 fell 06/26/22 with resulting left femur fracture, left scalp laceration and right elbow skin tear. Left hip fracture resolved with a total left hip hemiarthroplasty on 06/29/22. Surgical skin staples overlie the left lateral thigh. Left lateral scalp laceration with staples. Right elbow skin tear with dressing intact. (Date initiated 07/12/22). R38 is status post hospitalization secondary to unwitnessed fall with resulting left femur fracture. R38 is status post left hip hemiarthroplasty. R38 now requires supervision to total assist with ADL (Activities of Daily Living) care. (Date initiated 07/06/22). Interventions: History of Falls. Fall Risk Level: At risk. R38 is at risk for falls r/t (Related to) confusion, deconditioning, gait/balance problems, and unaware of safety needs. Unwitnessed fall on 06.26.22 with resulting left hip fracture, left scalp laceration, right elbow skin tear.

Initial Report dated 06/27/22 documents in part: On 06/26/22 at approximately 15:30, resident was heard screaming and observed on the floor as R38 had a fall. R38 complained of leg pain and had a 3 cm (Centimeter) laceration to the parietal area of the head. R38 was sent to the hospital. Final report dated 07/01/22 documents in part: Per staff, R38 is able to transfer out of bed and attempts to walk without assistive device. R38 has a history of attempting to walk around her (R38) room without assistive device. The origin of the injury occurred due to a fall. Resident lost her (R38) balance when trying to close the bathroom door. There was no witness to this incident.

R38 hospital Record dated 06/27/22 documents

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(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
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in part: R38 presented to the emergency room for an evaluation following an unwitnessed fall. Staples were placed to the left scalp following laceration. Noted left hip fracture on Xray pelvis. CT (Computed Tomography) Head: right posterior scalp soft tissue swelling. Active problems Closed fracture of left femur, Scalp Laceration. Patient was brought to emergency department s/p (Status post) unwitnessed fall. R38 was found on the bathroom floor, laceration on left occiput. Left femoral neck fracture, s/p left hemi-arthroplasty on 06/29/22. Admitting Diagnosis Closed fracture of left femur. Left hip a left posterior scalp with staples. Skin staples were placed to left scalp following laceration.

R38 Physician Order dated 07/06/22 documents in part: for surgical consult about staple removal head and hip after 2 weeks.

On 07/27/22 at 11:07 AM, V4 (Registered Nurse/RN) stated "R38 had an unwitnessed fall on 06/24/22. R38 said that she (R38) was looking for something and lost her (R38) balance when she (R38) fell. R38 is a high fall risk. The fall interventions are in the progress notes. There are no fall interventions in the care plan yet. We educated R38 to not get out of bed. R38 does not have any floor mats but uses an abductor pillow when in bed. When a resident falls, the nurse is notified by the Certified Nurse Assistant (CNA), the resident is assessed, if there is a complaint of pain we immobilize before transferring, inform the doctor and notify the family. Residents that are a fall risk, the bed is in a low position, floor mats, call light in reach, frequent rounds, and monitoring."

On 07/27/22 at 12:31 PM, V4 (Registered Nurse/RN) stated "R38 is a resident from

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	IL6008957	A. BUILDING: _____ B. WING _____	C 07/29/2022

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assisted living, R38 had an unwitnessed fall and was noted by the bathroom. Upon investigation R38 was trying to use the bathroom and on the way back lost her (R38) balance and was found by the nurse on duty by the bathroom door. R38 has had multiple falls. The interventions in the care plan are to remind R38 to use the walker. All I recall R38 was a standby assist prior to the fall and tends to get up on her own. A head-to-toe assessment was done, and a laceration was assessed somewhere on the head, pain to the leg and there was a femur fracture."

On 07/27/22 at 03:08 PM, V7 (Certified Nurse Assistant/CNA) stated "I was working on Sunday 06/26/22 and R38 was assigned to me. We had just come in, took vital signs, made rounds, and got the dinner orders. I was at the CNA (Certified Nurse Assistant) station near the nurse station with another CNA. We heard a big bang and went room to room then found R38 on the floor one half hour into the shift change about 03:30 PM. R38 head was towards the bathroom door and R38 was between the bed and the bathroom. I asked R38 if anything hurt and did, she (R38) hit her (R38) head. At first R38 denied hitting her (R38) head. We got R38 and sat R38 on the bed. R38 had a hat on and wanted to lay down. I noticed blood spilling on the pillow from the left side of R38 head. R38 head was actively bleeding. The hat was removed, and one nurse applied pressure while the other nurse went to call the doctor. R38 was holding onto the left hip and did not complain of pain until she (R38) was gotten into bed. R38 was sent to the hospital. R38 was mobile and would walk with her (R38) family member. R38 would sometime use the walker and sometimes she (R38) did not use the walker. The walker was at the foot of the bed. R38 would go to the bathroom unassisted because we would

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S9999	Continued From page 14 see evidence of R38 not flushing the toilet. I believe R38 was a high fall risk. The fall interventions were to have the call light near the bed and let staff know when R38 had to go to the bathroom. R38 was forgetful. When I would see R38 in the doorway without her (R38) walker I would remind R38 to use the walker. R38 was a one assist." On 07/27/22 at 03:58 PM, V12 (Registered Nurse/RN) stated "on 05/19/22 R38 was in the wheelchair because R38's son had just visited. I asked if R38 wanted to go to bed so I asked the CNA to help R38. A little while we were about to go to R38's room, R38 was on the bathroom floor. R38 said that she (R38) wanted to use the bathroom and she (R38) thought she (R38) could do it by herself (R38). R38 is a high fall risk, that's why I kept an eye on R38. The fall interventions that were in place are call light in reach, frequent rounding, bed in lowest position, and floor mats. R38 most recent fall was on 06/26/22. R38 always wanted to walk. When doing the nursing report the CNA heard R38 screaming and found R38 on the floor. R38 said her (R38) left leg hurt. R38 leg was immobilized, and we transferred R38 to the bed. When assessing R38 in bed there was a laceration to the left parietal area. R38 was sent to the hospital. R38 was impulsive and would get out of bed. R38 really wanted to go to the bathroom on her (R38) own. I witnessed R38 going to the bathroom. R38 did not use the walker because the walker was near the door of her (R38) room. R38 fall interventions were frequent rounding, give something to occupy her, floor mats, encourage not to get out of bed on own and make sure clean and dry. An abductor pillow was initiated after the hospitalization." On 07/28/22 at 09:35 PM, V8 (Certified Nurse	S9999		

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S9999	Continued From page 15 Assistant/CNA) stated "me and a coworker were at the CNA care station. We heard a bang and R38 was found lying on the floor by the bathroom. We sat R38 on the bed and R38 CNA notice R38's head was bleeding. R38 tried to do things a lot on her (R38) own and would not ask for assistance. On 07/28/22 at 10:32 AM, V10 (Nurse Practitioner/NP) stated "I saw R38 two times. One on 07/20/22 and 07/27/22. R38 had falls on 05/19/22, 06/24/22 and 06/26/22. R38 is considered a high fall risk. R38 had injuries due to the fall that happened after the fall (sic). The laceration to R38's head could have been avoided. R38 was diagnosed with a left hip fracture 06/26/22. A resident could have osteoporosis and it is hard to explain because there was no bone density and R38 is 96 years old. R38's doctor is on vacation." On 07/28/22 at 01:31 PM, per telephone interview V11 (MDS Coordinator) stated "the care plan is to be updated as soon as possible. The purpose of the fall interventions is to prevent further falls. All residents are at risk for falls, even if they are alert and oriented. The base line care plan is done when the resident is admitted. The nurse generates the baseline care plan. I put an at risk for falls care plan as soon as the resident is admitted. R38 had a fall on 05/19/22, 06/24/22 and 06/26/22. R38's admission dated is 05/10/22." On 07/28/22 V1 (Administrator) stated "I see the care plan for R38 was initiated on 07/12/22 after readmission." On 07/27/22 at 12:44 PM, V6 (Ombudsman) stated "the facility has a lot of falls."	S9999		

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S9999	Continued From page 16 On 07/27/22 at 03:55 PM, V1 (Administrator) stated "we do not have a toileting policy. Toileting is based on cognition and the need for assistance while toileting." Policy: Titled "Fall management, Long - Term Care" revised 02/17/22 documents in part: Falls are a major cause of injury and death among elderly people. About 1,800 older adults living in long - term care facilities die each year from fall - related injuries, and those who survive typically sustain hip fractures and head injuries that result in permanent disability and reduces quality of life. Special Considerations: After a fall, review the resident's medical history to determine whether the resident is at risk for other specific complications. Complete a fall risk assessment and revise the resident's care plan to include interventions to prevent future falls. Documentation: After a fall, complete a detailed incident report to help track frequent resident falls so that the facility can implement prevention measures for high - risk residents. Titled "Fall Prevention, long-term care" undated document in part: Preventing falls begins with identifying residents who are at greatest risk. Ensure the resident's care plan addresses the fall risk. Fall prevention should be individualized and comprehensive for each resident. (A)	S9999		