Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005722	A. BUILDING: ______ B. WING ______	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFT REHABILITATION & NURSING	700 NORTH MAIN STREET EUREKA, IL 61530

(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 Annual Licensure Survey.	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210b) 300.3240b) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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resident to meet the total nursing and personal care needs of the resident.

Section 300.3240 Abuse and Neglect

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act)

These Requirements are not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure an ambulatory resident with a history of known aggressive behaviors was monitored to prevent resident to resident verbal and physical abuse and failed to ensure residents were free of resident to resident verbal and physical abuse for three of four residents (R31, R34, R51) reviewed for abuse in the sample of 41. This failure resulted in R51 and R31 calling R34 a name using foul language, R34 wandering into R51's room and attempting to lift R51 out of R51's wheelchair resulting in R51 being fearful of R34. This failure also resulted in R34 wandering into R31's room, placing R34's hands on R31, attempting to pull R31 out of R31's room and then shoving R31 in the back.

Findings include:

The facility's "Abuse, Neglect, and Exploitation" policy, revised, 6/8/20, states, "Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary

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S9999	Continued From page 2 seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subject to abuse by anyone, including, but not limited to: facility staff, other residents, consultants, contractors, volunteers or staff of other agencies serving the resident, family members, legal guardians, friends, or other individuals. Definitions: 2. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful means the individual deliberately, not that the individual must have intended to inflict injury or harm. 3. Verbal abuse means the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance regardless of their age, ability to comprehend, or disability. 5. Physical Abuse includes but not limited to hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment." R34's Facesheet documents R34 with diagnoses to include but not limited to: unspecified dementia with behavioral disturbance, cognitive communication deficit, anxiety disorder, and major depressive disorder. R34's Brief Interview for Mental Status	S9999		

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documents R34 with severe cognitive impairment.

R34's "Wandering Risk Assessment", dated 12/2/21, documents R34 as a high risk for wandering.

R34's current Care Plan, states, "I wander with no rationale purpose, seemingly oblivious to needs or safety due to Dementia. Remove/redirect resident from other resident's rooms and/or unsafe situations or nonresident areas." This same Care Plan states, "(R34) is/has potential to be verbally/physically aggressive r/t (related to) Anger, Dementia, Poor Impulse Control."

R34's Nursing Notes on 3/17/22 documents R34 to be "agitated" and "combative" with staff.

R34's Health Status Note on 4/1/22 at 12:14 P.M., states, "(R34) becoming increasingly agitated. Took PRN (as needed) Xanax approx. (approximately) 20 min. (minutes ago). (R34) hit CNA (Certified Nursing Assistant) in the face when CNA attempting to redirect d/t (due to) resident frequently trying to go into other resident's rooms."

R34's initial "State Report" form, (undated), provided by V1/Administrator on 4/7/22, documents on 3/19/22, R34 allegedly lifted another resident's chair (R51), scaring the resident and an investigation was initiated.

R34's five-day follow-up report to the local state agency states, "On 4/6/22, (V1/Administrator) informed by (V4/Director of Business Office Development) of possible incident between (R34) and (R51) that occurred on 3/19/22. Reported that (R34) lifted (R51's) wheelchair and scared

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(R51)." This same report documents on 4/7/22 around 3:00 P.M., V23 (Resident Aide) telling V1 that "on second shift (R34) was in (R51's) room and (R34) tried lifting (R51's) wheelchair while (R51) was sitting in it. (V23) also stated that (R34) laid on the floor of (R51's) room and (V23) had to get a nurse to come in and help get (R34) out of (R51's) room." "(V1) spoke to (V24/Certified Nursing Assistant) on 4/7/22. (V24) stated (V24) does recall helping (V23) redirect (R34) out of (R51's) room. (R34) had entered (R51's) room through the joined bathroom. (R51) had stated that (R34) lifted (R51's) wheelchair. (V1) spoke to (R51) on 4/9/22. (R51) stated that (R34) raised (R51's) wheelchair while (R51) was in the wheelchair and it scared her. (R51) says she feels safe now that (R34) has been moved to another hallway." "Disposition: On 4/9/22, the IDT (Interdisciplinary Team) discussed the altercation between (R34) and (R51) and implemented intervention of staffing 1:1 (one on one) and room change for (R34)."

R34's initial "State Report" form, (undated), provided by V1/Administrator on 4/7/22, documents on 3/19/22, R34 allegedly hit another resident (R31) and an investigation was initiated.

R34's five day follow-up report to the local state agency states, "On 4/6/22, (V1) informed by (V4) of possible incident between (R34) and (R31) that occurred on 3/19/22. Staff member (V23) stated that (R34) hit (R31) in the hallway. This same report states, "(V1) spoke to (V23) by phone on 4/7/22 around 3:00 P.M., (V23) stated that (V23) observed (R34) hit (R31) on her back." "On April 9, 2022, (V1) and (V2/Director of Nursing) watched the video footage of Hall 5 security camera from Saturday, March 19, 2022...The camera showed that at 5:54 P.M., (R34) walks

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S9999	Continued From page 5 into (R31's) room, (R34) guides (R31) out of her room into the hallway, the guide was by (R31's) arms, then (R34) lightly shoves (R31's) back...There was no harm observed but the shove from (R34) was intentional." "Disposition: On 4/9/22, the IDT (Interdisciplinary Team) discussed the altercation between (R34) and (R51) and implemented intervention of staffing 1:1 (one on one) and room change for (R34)." On 4/6/22 at 8:32 A.M., R34 was observed in R34's room in R34's wheelchair, R34 entered the bathroom that is shared with R51. R34 then exited the bathroom on R51's side of the room and went into the hallway through R51's doorway. At this time, R51 stated, "Get her away from me, she's trying to kill me. She scares me." No staff was present in the hallway at this time. On 4/6/22 at 9:11 A.M., R51 was sitting in R51's wheelchair. A test of the door alarms with R51's electronic wandering device was being conducted alongside V18 (Certified Nursing Assistant/CNA). R51 repeatedly asked about the whereabouts of R34 and why R34 acts the way R34 does. R51 stated, "I shouldn't say that I know why she does that. It just scares me. Can't (R34) get out of here?" On 4/6/22 at 9:15 A.M., V18 (Certified Nursing Assistant/CNA) stated, R34 and R51 do not get along. V18 stated there was an incident approximately one month ago when R34 came and tried to lift R51 out R51's chair. V18 stated, "(R34) is strong and when she's mad, it's not good." V18 verified R34 is already on 15-minute checks. On 4/7/22 at 12:45 P.M., V4 (Director of Business Development) stated that when performing staff	S9999		

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interviews about R34 lifting R51 out of R51's chair (on 3/19/22), V4 also found that staff reported to V4 that R34 hit R31 after R31 called R34 a b***h that same day (3/19/22).

On 4/8/22 at 4:40 P.M., R7 stated, "About a month ago, (R51) was sitting in her wheelchair in (R51's) room. (R34) came over there and grabbed a hold of (R51's) wheelchair (that R51 was sitting in) and started pulling and lifting it up. (R51) started yelling for help at that time. I would say it lasted about a minute."

R7's Brief Interview for Mental Status, dated 1/20/22, documents R7 is cognitively intact without memory impairments.

On 04/08/22 at 10:11 A.M., R51 stated, "I was in my room listening to my music (on 3/19/22) and (R34) came into my room and lifted the back of my wheelchair up three times. I thought (R34) was going to kill me. I was so damn scared. I went and ate with (R36) because I was so scared. I didn't want to go to the dining room without someone or be alone in my room. (R34) shouldn't still be allowed to mingle around me. It hasn't happened again since. I keep my eye on (R34). I'm sure (R34) would like to get a hold of me again. (R34) wasn't always my neighbor. People have wrote stuff down about this before, no one has done anything. I'm so scared of her. They told me she was going to be leaving, but she never does. I wish she wasn't right next to me."

On 4/8/22 at 12:48 P.M., V24 (Certified Nursing Assistant/CNA) stated, "I was there on 3/19/22 when (R34) tried to pick (R51) out of the wheelchair. It was probably around 3:00 P.M. or 3:30 P.M., before supper. I was at the nursing

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station, and I heard some commotion. I was not assigned to that hallway. I helped get (R34) out of (R51's) room. (R51) was very mad. (R51) said she didn't want to deal with that anymore and that she shouldn't have to. I believe (V23/Resident Aide) told the nurse. I don't remember who the nurse was. I did not tell (V1/Administrator) but it should be reported right away."

On 4/8/22 at 3:28 P.M., V23 (Resident Aide) stated, "On second shift on the weekend, (3/19/22), I was keeping an eye on (R34). I was the 1:1 for (R31). I heard (R51) yell, 'Get this B***h out before I kill her.' (R34) was grabbing (R51's) wheelchair and trying to get (R51) out of the chair. (R34) then sat in (R51's) recliner chair in (R51's) room. (R51) asked (R34) to get out of the chair and (R34) said, 'I'm not going anywhere.' It took three of us to get (R34) out of (R51's) room. We went through the shared bathroom to get (R34) back into her own room. (R51) called (R34) a B-word and I think that is what triggered her. Once (R51) said the B-word is when (R34) got aggressive. (R31) also called (R34) a B-word and (R34) smacked (R31) that same day. (R51) is scared of (R34) now because of the way (R34) picked (R51) up. Every time I go in that hallway, (R51) asks me if (R34) is around. I reported all of this to (V1/Administrator) the next day."

On 4/8/22 at 5:03 P.M., V1 (Administrator) stated, "The staff should have called me right away. It says right on the outside of my door that I am the Abuse Coordinator and I even carry an abuse phone and the phone number is posted as well. We just in-serviced staff on who the abuse coordinator was and when to call in mid-February (2022). Waiting until the next day (to report potential abuse) is unacceptable. I would have

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come right in. I didn't know anything about this. We are going to discuss the best placement for (R34). We have to look at the census. (V4/Director of Business Development) first made me aware of this incident with (R34) the day before yesterday (4/6/22). (R34) wanders. Someone should always be with (R34). There should be some sort of documentation of (R34's) behavior in (R34's) medical record (about the 3/19/22 incident) and there is not." At this same time, V1 verified no new interventions or changes (after the 3/19/22 incident) have been put into place to keep other residents safe from R34.

On 4/9/22 at 10:35 A.M., V31 (Certified Nursing Assistant/CNA) stated that R34 can be "violent to anyone and everyone."

On 4/9/22 at 3:30 P.M., After watching video surveillance, V1 verified on 3/19/22 that, R34 grabbed hold of the back of R51's wheelchair after wandering into R51's room, R34 wandered into R31's room, R34 shoved R31, and R34 then wandered again into R51's room.

On 4/9/22 at 3:55 P.M., R36 stated, "It's been several weeks ago now, but I was in my room about to go out the door. (R51's) room is right across from mine, so I can see everything. I believe (R34) came into (R51's) room from the bathroom door. (R34) was behind (R51) and lifted her chair a few times where (R51) slid just about out. (R34) does impulsive things. (R51) was yelling for help and saying 'stop, stop.' (R34) finally let (R51) go. The staff came and tried to get (R34) out of (R51's) room. (R51) was so scared. (R51) didn't want to be around her. (R51) was scared that (R34) would come through her bathroom door again. (R51) went to lunch (in the dining room) with me a couple times. I think

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because (R51) was too scared to stay there and see (R34)."

R36's Brief Interview for Mental Status, dated 2/23/22, documents R36 is cognitively intact without memory impairments.

(B)

2 of 2

300.610a)
300.1210 b)5)
300.1210 c)
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 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

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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.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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.

Based on observation, interview and record review the facility failed to ensure the facility's electronic wandering door management system was in complete working order for eight (R3, R6, R17, R22, R31, R34, R47 and R51) of eight residents reviewed for wandering, failed to ensure a resident under one to one supervision was not left unattended, failed to complete neurological checks on a resident with an unwitnessed fall. In addition, the facility failed to ensure care planned interventions for falls and one to one supervision were implemented for one of seven residents

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S9999	Continued From page 11 (R31) reviewed for accidents in the sample of 41. This failure resulted in R31 having an unwitnessed fall that resulted in a laceration and nasal bone fractures. Findings include: 1. The facility's Fall Risk Assessment" policy, revised 12/1/20, states, "It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. 4. The "At Risk for Falls" care plan will include interventions, including adequate supervision, consistent with a resident's needs, goals, and current standards of practice to reduce the risk of an accident. 5. Monitor the effectiveness of the care plan interventions, and modify the interventions as necessary, in accordance with current standards of practice." The facility's "Incidents, Accidents and Supervision" policy, revised 1/30/22, states, "Policy: The resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary. Definitions: Accidents refers to any unexpected or unintentional incident, which results in injury or illness to a resident. Fall refers to unintentionally coming to rest on the ground, floor, or other lower level." "3. Implementation of Interventions-using specific interventions to try to reduce a resident's risks from hazards in the environment. The	S9999		

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LOFT REHABILITATION & NURSING	700 NORTH MAIN STREET EUREKA, IL 61530

(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
S9999	Continued From page 12 process includes: a. Communicating the interventions to all relevant staff. d. Documenting interventions (plans of action developed by the QAPI (Quality Assurance Performance Improvement) Team or care plans for the individual resident). e. Interventions are based on the results of the evaluation and analysis of information about hazards and risks and are consistent with relevant standards, including evidenced-based practice. h. Resident-directed approaches may include: i. implementing specific interventions as part of the plan of care ii. supervising staff and residents, etc. iii. facility records document the implementation of these interventions. 5. Supervision-Supervision is an intervention and a means of mitigating accident risk, The facility will provide adequate supervision to prevent accidents. Adequacy of supervision: a. Defined by type and frequency b. Based on the individual resident's assessed needs and identified hazards in the resident environment." R31's Face sheet documents R31 with diagnoses to include but not limited to: unspecified Dementia with Behavioral Disturbance; Alzheimer's Disease; Unsteadiness on Feet; Repeated Falls; and Cognitive Communication Deficit. R31's Fall Assessment, dated 1/6/22, documents R31 is at a high risk for falling. R31's IDT (Interdisciplinary Team) note, dated 3/21/22 and 4/7/22, documents R31's BIMS (Brief Interview Mental Status) score a of 0 (out of 15) indicating severe cognitive impairment. R31's MDS (Minimum Data Set) Assessment, dated 2/16/22, documents R31 requires limited assistance of one plus person physical assist for transfers, bed mobility, and walking between	S9999		

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locations in R31's room.

R31's current Care Plan documents the following: R31 wanders with no rational purpose, seemingly oblivious to needs or safety throughout the healthcare center and documents an intervention initiated 10/5/21, of "1:1 (one to one) supervision."; R31 requires staff supervision for transfers for safety; R31 is able to ambulate independently with staff supervision but requires limited staff assist of one for safety and direction; R31 is a high risk for falls related to incontinence and poor safety awareness due to cognitive impairment and documents interventions as "Fall 3/18/22-Hazard strips to bed with a date initiated of 3/31/22. Fall 4/4/22-staff education 1:1 with a date initiated of 4/4/22.

R31's Nursing Notes on 3/17/22 at 1:59 P.M., states, "(R31) exhibiting behaviors almost all shift such as wandering, agitation, repetitive questioning/statements. Requiring one on one with staff for redirection."

R31's Social Service Note on 2/16/22 document R31 has a one-to-one companion that monitors her.

R31's Health Status notes on 3/24/22 and 4/5/22 document R31 continues to be a one-to-one supervision with staff.

R31's Fall Incident Report on 3/18/22 states, "(R31) fell in her room beside her bed. (R31) was found on her hands and knees over the garbage can. (R31) tripped over the bedside garbage can and landed on her hands and knees. Fall was not witnessed but (R31) denies hitting her head. (R31) complains of pain in her knees and was given Tylenol for pain. (R31) unable to give

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S9999	Continued From page 14 description." This same report documents no witnesses could be found. R31's IDT (Interdisciplinary Team) Note on 3/31/22 documents a root cause of R31's 3/18/22 fall as "Transferring self out of bed without assistance" and interventions implemented as "Hazard Strips next to bed." Staff Education is documented as "Monitor (R31's) gait when up walking or trying to get out of bed." R31's Post Fall Observation, dated 3/18/22 at 5:41 P.M., documents R31 was found on the floor in R31's room on her hands and knees and documents R31's fall was not witnessed but nearby staff did hear the fall occur. Detailed Description of Fall states, "(R31) tripped over the garbage can at (R31's) bedside and landed on (R31's) hands and knees." R31's Fall Incident Report on 4/4/22 states, "Staff entered (R31's) room after being in another resident's room. (R31) sitting on floor. Notes to have a gash in the center of forehead...Left knee noted to be swollen with raised purple area. (R31) rubbing knee stating, 'it's cold outside'. Uncertain of (R31's) cognitive status prior to fall. Pupils equal and reactive. 911 called at 0420 (4:20 A.M.). Injuries observed at time of Incident: Laceration top of scalp." "Predisposing Physiological Factors: confused, gait imbalance, weakness/fainted" are checked. "Predisposing Situation Factors: Ambulating without Assist" is checked. This same report documents no witnessed found. R31's IDT Note on 4/7/22 documents a root cause of R31's 4/4/22 fall as "rolled out of bed." This same note documents R31 was last seen at 2:45 A.M. in bed, Neuro (Neurological) checks x	S9999		

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(times) 72 hours, Monitor for signs/symptoms of injury after fall and report any abnormalities to R31's physician.

R31's Initial Report to the local state agency, undated, states, "(R31) BIMS (Brief Interview Mental Status) score of 0 (severe impairment); staff entered room after being in another resident's room. (R31) sitting on the floor. Noted to have a gash in the center of forehead. B/P (Blood Pressure) 136/88, p (Pulse) 100, r (Respirations) 22. Left knee noted to be swollen with raised purple area. Pupils equal and reactive. Sent to ER (Emergency Room) for further evaluation. Facility received notification from ER: (R31) has a 5 cm (Centimeter) laceration to center of forehead, (R31) received sutures of forehead (laceration, concussion and has closed fracture of nasal bone. Types of injuries: Laceration of forehead, closed fracture of nasal bone, concussion/head injury."

R31's five-day follow-up to the local state agency documents on 4/4/22, R31 was observed sitting on the floor with a gash in the center of R31's forehead. This report documents, "(V1/Administrator) interviewed (V34/Certified Nursing Assistant) on 4/4/22. (R31) was observed in the (R31's) room at 4:00 A.M. by (V34) and (R31) was still sleeping. (V34) stated he left the room to attend to activated call light. Upon returning to the room, (V34) observed (R31) sitting on the floor. Noted to have laceration in center of forehead. Physician notified and received order to transfer to (local area hospital) by ambulance for further evaluation. POA (Power of Attorney) notified of transfer for evaluation. Facility received notification from ER (Emergency Room) regarding diagnosis of 5 (five) cm (centimeter) laceration to center of forehead,

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concussion and closed fracture of nasal bone. Disposition: Care Plan reviewed and updated to include educate staff regarding 1:1 (one to one). (V1) sent email to (staffing) agency that (V34) is not allowed to return (to facility to work)."

R31's Post Fall Observation dated 4/4/22 at 5:28 A.M., documents R31's fall was unwitnessed and when staff entered (R31's) room (R31) was sitting up with legs flexed up to hip. Arms at side."

R31's CT (Computed Tomography) without contrast obtained at the local area hospital on 4/4/22 documents an impression of "nasal bone fractures."

R31's local area hospital Emergency Department summary, on 4/4/22, states, "(R31) was found on the floor of (R31's) room earlier at night with a laceration injury to forehead. This same report states, "5 (five) cm laceration sub Q (subcutaneous) lac (laceration) located in the center of (R31's) forehead. Nose: edematous (swollen) with mild deformity." This note also documents R31's forehead laceration was repaired with sutures.

On 4/5/22 at 10:05 A.M., R31 was noted to be lying in bed with eyes closed. V25 (Certified Nursing Assistant) was sitting next to R31's side. V25 stated that V25 is sitting with R31 for R31's ordered one to one supervision. V25 stated that V25 has been working at the facility since September 2021 and states that R31 has been one to one supervision that whole time. At this time, R31 is noted to have purple and yellow bruising surround both of R31's eyes, a laceration to the center of R31's forehead with sutures, bruising to R31's nose, and a nasal deformity noted. At this time, no fall strips were noted to the

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floor next to R31's bed.

On 4/7/22 at 9:02 A.M., No fall strips were noted on the floor next to R31's bed. V25 verified no fall hazard strips were on the floor next to R31's bed. R31 was lying in bed with eyes closed. R31's facial bruising, laceration with sutures, and nasal deformity remain the same.

On 4/7/22 at 10:35 A.M., V2 (Director of Nursing) verified that the hazard strips had not been placed onto the floor next to R31's bed. V2 stated, "They should be there. I will notify maintenance."

On 4/7/22 at 11:53 A.M., V1 (Administrator) and V2 (Director of Nursing) stated that V34 (CNA/Certified Nursing Assistant), "(On 4/4/22), took it upon himself to say that (V34) would do the 500 hall and also one to one (R31). Apparently, there was a call in and instead of calling (V2) who was on call, they (facility staff) made a schedule change without notifying (V2)." At this time, V2 stated, "I was on call that night and I did not get any notification about a schedule change or call-in. They (facility staff) know not to make changes without notifying the supervisor on call. (R34) should never have had the 500 hallway assignment and the one to one with (R31). The one to ones should never be out of sight of the resident."

On 4/7/22 at 12:15 P.M., V1, V2 and V13 (Certified Nursing Assistant/Scheduler) stated, that on 3/18/22, V13 was assigned the 1:1 with R31. V2 stated that V13 had to leave R31's room to attend to another resident, so V2 sat outside R31's room in the hallway to be R31's 1:1 until V13 returned. V2 stated that V2 briefly forgot that V2 was not to leave out of eyesight from R31. V2

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stated V2 began walking up the hallway and heard a noise that sounded like a bedside table falling over. V2 stated V2 ran back down into R31's room and found R31 on the floor on R31's hands and knees. V2 stated R31 had been asleep in R31's bed prior. At this time, V1, V2, and V13 verified R31 should not have been left unsupervised and that no one was with R31 at the time of R31's fall. V2 stated, "One to one means 24/7."

R31's Neurological Assessment Flowsheet, dated 4/4/22-4/6/22, is not finished being completed by nursing staff after R31's return from the hospital.

On 4/7/22 at 12:18 P.M., V2 verified the Neurological Assessment Flowsheet (Neuro Checks) should continue to be completed after the resident comes back from the hospital if it is still within the 72 hours after the unwitnessed fall. V2 verified R31's Neuro checks were not completed and should be since R31's 4/4/22 fall was unwitnessed.

Phone calls with messages left to speak with V34 (CNA) were not returned.

2. The facility's (Name of Door Management System) Installation Manual, issued 8/25/20, documents the electronic door management system monitors residents who are at risk of wandering away from a facility. This manual documents the door management system is mounted near a monitored door or exit and when the system receives a response from an elopement risk resident's pendant, it will lock the exit and/or sound an alarm and display information on the monitor's display. The exit door is normally not locked by the electronic door management system and only when a monitored

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S9999	Continued From page 19 pendant is detected will the exit be locked preventing escape. The facility's "Elopements and Wandering Residents" policy, dated 3/1/20, states, "The facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. 1. The facility is equipped with door locks/alarms to help avoid elopements. " On 4/6/22 at 10:15 A.M., V1 (Administrator) provided a list of residents in the facility who are a high risk for wandering/elopement and who wear pendants that would activate the facility's door management system. R3, R6, R17, R22, R31, R34, R47 and R51 are noted. On 4/6/22 between the hours of 10:20 A.M. and 11:48 A.M., a facility-wide check of the door management system was conducted with V26 (Maintenance Assistant). V26 stated when the resident's pendant gets within proximity of the magnetic door lock, the lock will illuminate red, and the door will lock. V26 stated on the keypad controller, the "external power" light should be illuminated green. On 4/6/22 at 10:20 A.M., the light on the keypad controller for the external power at the 500 wing hallway exit door alarm was not illuminated. When the pendant was brought towards the magnetic door lock and sensor, the light did not illuminate red, and the door was able to be opened. At this time, V26 stated, "That needs fixed, I shouldn't be able to open the door."	S9999		

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S9999	Continued From page 20 On 4/6/22 at 10:23 A.M., the light on the keypad controller for the external power at the 300 wing hallway exit door alarm was not illuminated. When the pendant was brought towards the magnetic door lock and sensor, the light did not illuminate red, and the door was able to be opened. On 4/6/22 at 10:26 A.M., the light on the keypad controller for the external power at the 400 wing hallway exit door alarm was not illuminated. When the pendant was brought towards the magnetic door lock and sensor, the light did not illuminate red, and the door was able to be opened. at 10:31 A.M., V26 stated, "The external power is necessary. It's the main power source that's giving us our trouble. The magnet is needed to lock the door down." On 4/6/22 at 10:32 A.M., the light on the keypad controller for the external power at the multi-purpose room exit door alarm was not illuminated. When the pendant was brought towards the magnetic door lock and sensor, the light did not illuminate red, and the door was able to be opened. On 4/6/22 at 10:37 A.M., the light on the keypad controller for the external power at the 200 wing hallway door alarm was not illuminated. This door exited to a stairway to the lower level. When the pendant was brought towards the magnetic door lock and sensor, the light did not illuminate red, and the door was able to be opened. On 4/6/22 at 11:27 A.M., a set of double glass exit doors by the beauty shop were noted. The door on the left was activated and monitored with the magnetic door lock system. The door on the	S9999		

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S9999	Continued From page 21 right was not set up with the magnetic door lock system and was unlocked. V26 stated the company did not install the magnetic door lock system on the door on the right side for an unknown reason. V26 stated the expectation was that the right door would remain locked at all times. At this time, V26 was able to open the right door due to it being unlocked. V26 stated, "No one is supposed to unlock that door. If someone unlocks that then someone is out that door." On 4/6/22 at 11:44 A.M., a set of double doors were noted on the left side of the therapy room. The magnetic door lock box was partially installed on the door with parts of it disassembled and sitting in the windowsill to the right of the door. V26 stated when the door was opened, the magnetic lock box had fallen off. V26 stated, after the installers (of the door management system) were gone, we found this problem. V26 stated, "The alarm is not functional right now. If we want it locked, we need to get it working." At this time, V26 verified no active alarms are placed on the double doors and that the double doors are an immediate exit to the outside. On 4/6/22 at 12:30 P.M., V1 (Administrator) verified the external power source had been tripped and that was the reason the door magnets were not working as they should. (A)	S9999		