STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005375	A. BUILDING: _____ B. WING _____	C 05/17/2022

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S 000	Initial Comments Complaint Investigation 2291695/IL144203 Facility Reported Incidents: of 04.09.22/IL146058 of 02.16.22/IL144119 of 02.22.22/IL144556 of 03.26.22/IL145614 of 03.29.22/IL146435	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 3): 300.610a) 300.1010h) 300.1210b 300.1210d)5) 300.1820c)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h)The facility shall notify the resident's physician	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. Section 300.1210 General Requirements for Nursing and Personal Care 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: 5)A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.	S9999		

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S9999	Continued From page 2 Section 300.1820 Content of Medical Records c) In addition to the information that is specified above, each resident's medical record shall contain the following: 3) Nurse's notes that describe the nursing care provided, observations and assessment of symptoms, reactions to treatments and medications, progression toward or regression from each resident's established goals, and changes in the resident's physical or emotional condition. These regulations were not met as evidenced by: Based on interview and record review the facility failed to identify or have a treatment plan in place for a facility acquired venous stasis wound to right heel for 1 of 3 residents (R2) reviewed for skin assessments. This failure resulted in R2 being at the local hospital for a chronic treatment where the right heel ulcer was noted to be foul smelling with purulent drainage, and a black erythema around it, R2 was diagnosed and treated with intravenous antibiotic for osteomyelitis of the right heel at the local hospital. Findings Include: R2 was sent out to hospital on 2/12/22 and returned to facility on 2/28/22. Documented in nurse's note that R2 was transported to local hospital at 4:20pm on 2/12/22. Emergency department documentation on 2/12/22 at 1800, reads in part: patient has bilateral lower leg edema, with excoriation to bilateral shins, and several ulcers to right heel	S9999		

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S9999	Continued From page 3 and left heel and ankle. Ulcer on right heel is black with erythema around it and foul smelling. History and Physical documentation on 2/13/22 at 1039, reads in part: Right heel wound with foul smell and some purulence. May have infection on her chronic wounds, noted that some of them appear foul smelling in the ER. R2 admitted in ICU with admitting diagnoses of supratherapeutic INR, Sepsis, and Hypotension. R2's hospital record dated 2/25/22 at 10:29am, reads in part: Vascular surgery consulted for perfusion to assist for wound healing. Podiatrist is seeing patient for her heel wound and recommended amputation. However family is not agreeable to amputation and would like antibiotics. R2 found to have osteomyelitis in right heel wound. R2's Facility Treatment Administration Record (TAR) from January 2022 to February 2022 reviewed. Noted to have treatments for right first great toe, left leg and right leg. Treatment rendered for all three sites. There is no noted treatment for right heel. Facility wound doctors notes (with date of service on 1/20/22) addressed and documented right great toe, left leg, and right leg, all sites with etiology of venous. There is no noted documentation for Right heel wound. On 4/19/22 at 11am, V4 (Wound Nurse) stated that currently R2 has 2 wound sites. R2 is with left lower leg and right planter heel. Right plantar heel identified on 3/1/22 upon readmission to the facility from hospitalization. Prior to hospitalization of 2/12/22. Wounds were All Venous Stasis. Vascular. Left leg identified 11/3/21. Right first great toe	S9999		

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S9999	Continued From page 4 identified 1/20/22 and the right leg shin identified 11/3/21. On 4/19/22 at 2:40pm, V3 (DON) stated that R2's right heel wound happened in the hospital and not in the facility because there is no documentation that R2 has right heel wound when R2 was in the facility. V3 reported to reviewed hospital record of R2 upon return to the facility and read that R2 has right heel wound, but V31 also reported that the nurse on duty (V31) at the time R2 was sent out on 2/12/22, documented no new skin issue on 2/12/22. On 4/20/22 at 12:40pm, V31 (Nurse) stated that R2's wound treatment are ordered daily dressing change and done during morning shift nurses or wound nurse. "The only time I (V31) provided care on R2's wound was when the wound wrap was loose. I (V31) have not seen the wounds, I just have to rewrap the leg with gauze wrap. I (V31)was able to do body assessment for R2 prior to 911 transported R2 to local hospital. Before the family called 911, I already conducted the body assessment. I (V31) do not remember how many wounds R2 has, but I know I did skin assessment. I do not know the wound sites location". On 4/20/22 at 2:00pm, V30 (Wound Doctor) stated "I am aware now of the right heel wound upon readmission of R2. It is unlikely for the wound of R2's to have signs of infection if the wound is newly acquired, but I am not really sure what was going on with R2 medically. What I know is that R2 has chronic disease with vascular compromise. I have never seen the wound develop in minutes or hours and be diagnosed with osteomyelitis immediately. Wound could develop pretty quickly, my speculation with R2's	S9999		

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S9999	Continued From page 5 right heel wound is that it would take hours and even days for R2's wound to show signs of infections". V30 also stated that V30 stopped seeing R2's wound January 2022 because it was improving and the sites that V30 was treating were right leg, left leg and right great toe. Denied treating any right heel wound for R2 before the hospitalization on 2/12/22, V30 stated since the returned of R2, right heel wound is now identified and classified as venous stasis. Facility R2's shower sheet reviewed from January to February 2022. R2 received showers on scheduled shower days. Shower sheets dated 1/3/22, 1/6/22, 1/10/22, 1/17/22, 1/20/22, 1/24/22, 1/27/22, 1/31/22, 2/3/22, 2/7/22 and 2/10/22 shows (x) mark on right leg and right great toe skin alteration. There is no documented right heel skin alteration on shower sheets on dates mentioned. Facility unable to provide of any documentation of right heel wound prior to R2's hospitalization on 2/12/22. Hospital record 2/12/22 at 1702, White blood cell count (WBC) of 30K. Hospital record dated 2/13/22 reads in part: to continue with broad spectrum antibiotic for now, follow up blood culture and wound culture. Facility's Wound Care Program Care Guidelines with a revised date of July 3, 2019, reads in part: this facility adheres to the Federal and State Regulatory requirements for wound care management and the care guidelines for wound care established by the National Pressure Ulcer Advisory Panel. Timely identification of residents assessed to be at risk for skin breakdown.	S9999		

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S9999	Continued From page 6 Wound assessments for pressur3e, diabetic, venous and arterial wounds: Wound assessment documentation shall include but are not limited to: type of wound and/or ulcer, location, date, stage (if applicable), length, width and depth; wound bed description, wound edge description and if present, exudates, undermining, tunneling and wound related pain. (A) Statement of Licensure Violations (2 of 3): 300.610a) 300.1010h) 300.1210b) 300.1210d)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h)The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not	S9999		

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S9999	Continued From page 7 limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. Section 300.1210 General Requirements for Nursing and Personal Care 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: 3)Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These regulations were not met as evidenced by: Based on interview and record review the facility failed to conduct a comprehensive pain assessment and failure to notify the physician of a new onset of knee swelling and pain for 1 of 3	S9999		

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S9999	Continued From page 8	S9999		

residents (R13) reviewed for pain management. This failure resulted in R13 not being assessed and not receiving any orders for pain medication for over 24 hours after the new onset of pain which was a subsequent acute mildly displaced distal femoral diametaphyseal fracture.

Findings include:

On 4-22-22 at 10:08 AM, V36 (Nurse Practitioner) said on she does not remember facility calling on 4-5-22, to notify about onset of new right knee swelling. V36 said she would usually order x-ray for a new onset of swelling and new pain. V36 saw R13 on 4-7-22 and ordered right knee x-ray. V36 doesn't recall receiving page. In normal cases, V36 would have ordered x-ray.

On 4-22-22 at 10:39 AM, V35 (RN) said she assessed swelling on R13's right knee (verified with CNA) and worsened pain. R13 was taking scheduled pain medication and no further issues. Staff was monitoring R13. V35 paged NP, NP ordered X-ray for knee. V35 spoke to x-ray company because she had 2 x-rays to order (4-7-22).

On 4-22-22 at 11:10 AM, V37 (Radiology VP of Operations) said staff called on 4-7-22 at 11:15 AM to order X-ray. X-ray done on 4-9-22 at 1:36 AM.

On 4-27-22 at 12:14 PM, V3 (DON) said R13 has generalized chronic pain. Staff is monitoring R13's pain every shift. Pain should be monitored every shift and as needed. Based on R13's pain tracking (vital signs) and monitoring there is no consistent pain tracking documented. There are dates missing. V3 said there is no documentation of comprehensive pain assessment of the new

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S9999	Continued From page 9 onset of pain dated 4-5-22 and could not be present to surveyor. V3 said Comprehensive pain assessment is done as needed, annually, quarterly, and with incident. On 4-27-22 at 12:35 PM, V43 (Attending Physician) said he saw R13 on 4-6-22 for routine follow up visit. V43 does not recall being aware of new concerns of right knee swelling. V43 may not have seen right knee swelling because R13 is in bed and unable to talk. attending physician does not recall being told of new right swelling and this is not documented in his progress note. On 4-28-22 at 11:28 AM V2(Executive Director) said staff should immediately report new changes in condition to attending physician. The stat x-ray window should be within 4 hours. Routine x-ray should be within 24 hours or at scheduled time. X-ray was ordered on 4-7-22, the schedule date was 4-8-22, and service date fell on 4-9-22. Staff is responsible for calling radiology if the scheduled date was not met. Progress Note (MD) dated 4-5-22 08:48 documents while obtaining urine specimen for UA/CS (Urinalysis/Culture and Sensitivity) via straight catheterization noted some swelling of Rt knee. Resident was only able to verbalize that she has generalized pain, displayed baseline limited ROM in all extremities, refused any offered pain medication. She has multiple PMH (Past Medical History) including unspecified dementia, pain unspecified knee, primary osteoarthritis. Attending physician Progress noted dated 4-6-22 documents 88-year-old lady who is seen for routine follow-up at the nursing home. She is without new complaints at the time of visit, per	S9999		

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nursing, she had urinary tract infection. On vitals, her blood pressure is 133/64, temperature 97, pulse 73, weight 123.8. Musculoskeletal: up with assist. Plan: 20. Knee pain, Continue as needed pain medicine. No documentation of onset of right knee swelling noted.

NP Progress Note dated 4-7-22 documents Late Entry: Note Text: Subjective: Chief Complaints: Right knee pain HPI (History of Present Illness): An Interim history: Resident seen and examined, per request of daughter, for increased right knee pain; resident with known history of severe OA (Osteoarthritis)to knees.

Progress Note (Nurse Practitioner) dated 4-9-22 documents: Chief Complaints: Right knee pain HPI: Resident seen and examined for a follow up visit and assessment of recent complaints of increased right knee pain.

Radiology Report dated 4-9-22 documents acute mildly displaced distal femoral diametaphyseal fracture.

Radiology Investigation Report dated 4-18-22 documents on 4-7-22 at 11:14 AM, staff nurse ordered routine x-ray exam. Routine service date of exam was scheduled for 4-8-22. On 4-9-22 at 1:26 AM, x-ray technologist completed the exam.

Facility Agreement (Radiology) dated 8-1-21 documents provider shall provide services within 24 business hours or schedule a time for the service. The provider will promptly notify the facility if services time is unable to be met.

Notification for Change in Condition Policy (reviewed 7-28-21) documents the facility must inform the resident; consult with the resident's

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S9999	Continued From page 11 physician; and if known, notify the resident's legal representative or an interested family member when there is: a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). R13's Medical Records were reviewed, and document Comprehensive Pain Assessments dated 10-20-21, 4-26-22, and 4-27-22. There is no other documented Comprehensive Pain Assessments after 10-20-22 to 4-26-22. Pain Policy (reviewed 7-28-21) documents it is the policy of the facility to ensure that all residents are assessed for pain in every situation where there is potential for pain. For pain complaints and for situations/incidents that might result to pain (ex: fall incident, altercation, cuts, bruises, wound care, etc.), the nursing staff may document it in any part of the resident's medical record that includes Nurses Notes, Incident Report, and Medication Administration Record. (A) Statement of Licensure Violations (3 of 3): 300.610a) 300.1210b) 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	S9999		

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S9999	Continued From page 12 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. Section 300.1210 General Requirements for Nursing and Personal Care 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 regulations were not met as evidenced by: Based on interview and record review the facility failed to prevent an avoidable accident while allowing a resident identified to be a fall risk due to impaired mobility, to assist push another	S9999		

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resident in a wheelchair on the nursing unit. This affected 1 of 3 residents reviewed for avoidable accidents. This failure resulted in R10 pushing R3 around the nursing unit where R3 fell from the wheelchair and went to the local hospital where R3 was diagnosed with comminuted sub capital fracture of the right femoral, and a minimally displacement of the left nasal bone inferiorly anteriorly, had a hemiarthroplasty to repair the right hip.

Based on observations, interviews, and record reviews, the facility failed to provide a safe mechanical lift transfer by not following the Mechanical Lift Transfer Policy, and manufacter reccomendations, to include folding resident arms across the chest, bilateral siderails up during transfers, ensuring all extremities are clear of the mechanism while in operation. This affected 1 of 3 residents (R5) reviewed for safe mechanical transfers. This failure resulted in R5's right hand getting entangled in the mechanical lift causing a laceration to right middle finger and comminuted fracture in the distal phalanx of the 3rd digit.

Based on interview and record review the facility failed to maintain safety for a resident assessed to be at high risk for falls while performing a staff assisted shower for 1 of 3 (R8) residents reviewed for falls. This failure resulted in R8 being involved in a fall incident while being showered by a certified nurse aide resulting in R8 falling to the floor sustaining a laceration to the forehead requiring sutures at the local hospital.

Findings Include:

Facility Reported Incident (dated 2/22/22) reviewed, and reads in part: Facility reportable dated 2/22/22 reads in part: Date of incident

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S9999	Continued From page 14 2/22/22 at 12:20 pm (Time verified with V32, ADON on 4/22/22), location R3's room. CNA observed R3 fell forward on to the floor from R3's wheelchair while being wheeled out of her room by R10 (husband and resident on the 6th floor). CNA notified the nurse and the nurse immediately responded and observed the R3 laying on R3's right side in front of R3'sroom. Nurse noted swelling on the bridge of R3's nose and complaint of pain. R3 was sent to hospital. Final investigation dated 3/1/2022 reads in part: R10 (R3's husband) visiting the R3 when R10 decided to take R3 out from the room to the common area. The right wheelchair wheel hit the door frame and the wheelchair came to a sudden and complete stop. The stop forced the resident to move forward and fell on the floor face down. Hospital record reviewed. X-ray of the hip reveals comminuted sub capital fracture of the right femoral neck and resident had hemiarthroplasty on right hip. CT of maxillofacial without contrast revels minimally displaced of the left nasal bone inferiorly anteriorly. R3 is with diagnosis of Dementia and resides in the Dementia Unit (5th floor). R3 was assesses on 2/8/22 to be high risk for fall. BIMS (Brief Interview for Mental Status) score of 3 out of 15 (severe cognitive impact). R3's Minimum Data Set (MDS), section G (Functional Status) shows Locomotion on unit as extensive assistance with one person assist. R3 is high risk for fall, assessed on 2/8/22 and the day of the incident 2/22/22. R10 resides on the 6th floor, care planned for RESTORATIVE TRANSFER PROGRAM: R10 has an ADL Self Care Performance Deficit related to Limited ROM, Impaired Mobility	S9999		

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S9999	Continued From page 15 Decreased Endurance/Activity Tolerance (dated 10/28/21). Intervention: R10 requires Extensive Assist x 1 staff participation with transfers (dated 10/28/21). R10 is At Risk for fall related to the following contributing factors: 1) Generalized weakness related to Multiple complex/chronic medical diagnosis. 2) Inability to call for assist, decreased comprehension, impulsivity (dated 1/28/22).One of the care plan intervention for R10 fall care plan is: Provide R10 with staff assistance in areas of mobility, transfer, self-care as indicated (dated on 10/28/21). R10's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/19/22 section G (Functional Status) shows R10 Walk in room and walk in corridor as supervision with set up help only. R10 has a BIMS score of 14 out of 15. R3's hospital record reviewed and noted on 2/23/22 R3 had a Right Hip hemiarthroplasty. On 4/15/22 at 11:35am, interviewed 5th floor social service (V10) stated that R3 uses wheelchair and participates in activity. V10 reported that R10 visits R3 daily in the Dementia unit. R10 has a behavior of wheeling R3's wheelchair away from the hallway, however R10 is re-directable. I am not sure, how often R10 wheeled R3 back in R3's room, but there was an Activity Aide and CNA that could of redirected R10 not to wheel R3. "I am not sure who put R3 in her room at the date of the incident". On 4/15/22 at 12:00pm, interviewed V12 (6th floor Social Service) stated that R10 visits R3 in the Dementia Unit. R10 has a BIMS score of 8 out of 10, which means R10 has cognitive impairment. . R10 is aware of his safety and most	S9999		

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S9999	Continued From page 16 of the time, R10 is aware of the safety of others. On 4/15/22 at 11:20am, interviewed V9 (CNA assigned to R3 on 2/22/22) and stated that V9 is an agency CNA. 9 stated that before the incident on 2/22/22, V9 already observed R10 wheeled R3 in and out of R3's room. Per V9, the first time V9 observed this behavior, V9 asked the regular staff in the unit and the staff told V9 that it is okay for R10 to wheel R3, and that R10 and R3 are husband and wife. V9 denied putting R3 in her room that day (2/2/22). Per V9, he was assisting another resident in their room and V9 heard a noise and when V9 came out of the room, "I was coming out of another resident's room and I heard a noise, and then I saw R3 was on the floor, by R3's bed room doorway. The wheelchair was facing the outside of the room, so I guess that R10 was wheeling R3 outside her room. I called the nurse". V9 stated that the last time V9 saw R3 and R10 was in the dining room after lunch. V9 denied assisting R3 back to R3's room and does not know who placed R3 in R3's room. On 4/15/22 at 12:55pm, interviewed V8 (Nurse assigned to R3 on 2/22/22) stated that V8 did not witness the incident, V8 was just informed by staff. V8 stated V8 called 911 while other staff assisted with R3. On 4/19/22 at 20:10am, interviewed V21 (Fall Coordinator) stated that R10 alert times 3, came down to the unit (5th floor). R10 Par take activity with R3, wheeled her in the bedroom, and R10 routine was R10 would wheel R3 in the unit. On 4/19/22 at 2:40pm, V3 (Director of Nursing) stated "R10 is alert and oriented x 3. BIMS score of 14, and able to verbalize his needs. We don't have any policy about resident to resident	S9999		

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S9999	Continued From page 17 assistance with wheeling a wheelchair of another resident". On 4/20/22 at 2pm, V2 (Executive Director) stated that the facility does not have Supervision policy. Fall Prevention Program Guidelines policy with a revised date of 6/15/2019 reads in part: Fall prevention program shall be implemented to promote safety of all residents in the facility. This program shall include measures to determine the individual needs of each resident by assessing the risks for fall and the implementation of evidence0based prevention intervention. Procedure: Safety interventions shall be initiated and implemented for each resident identified at risk for fall. All assigned nursing personnel and facility staff shall be responsible for ensuring ongoing precautions are put into place and consistently maintained. R5 During the course of the survey, surveyor observed staff tending to residents. On 4-19-22 at 2:02 PM, surveyor observed CNA and Restorative Aide use mechanical lift to transfer R5 from reclining high back wheelchair to bed. Surveyor noted staff left R5's bilateral bed rails up during the mechanical lift transfer from wheelchair to bed. R5 is confused, nonverbal, and unable to carry conversation. On 4-15-22 at 11:00 AM, V3 (Director of Nursing/DON) is alert and oriented x 1. R5 has dementia and is un-directable. R5 has mood swings and be easily agitated and unpredictable. The guide for mechanical lift transfer is responsible for ensuring the resident is safe during transfer. The staff provided cues prior to	S9999		

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mechanical lift transfer. The staff should have continued to provide verbal cues throughout the transfer and a hand to hold to assure resident is safe during transfer. R5's left side rail was up during this mechanical lift transfer which R5 hit her head. R5 siderail was up during mechanical lift transfer. The siderail should not be up during mechanical lift transfers. Due to R5's behavior, staff should be providing verbal and nonverbal cues to calm the resident and alleviate behaviors.

On 4-21-22 at 10:34 AM, V32 (ADON) said during interviews with direct care staff, CNA and LPN said R5 was moving her head and hit her head on the side rail causing a laceration after being lowered into bed. V32 said, when transferring a resident using a mechanical lift, the siderails should be down to prevent bumping or resident injury. R13 was agitated, flailing her arms, and she touched the bar of the mechanical lift causing laceration and finger fracture. R13 was still agitated and moving her head side to side and hitting the side rail causing head laceration.

On 4-15-22 at 10:06 AM, V5 (LPN) said R5 is alert oriented x 1. R5 had dementia, difficult to redirect, and unable to make her needs known. R5 has a history of her flailing arms and hitting staff when providing care. R5 has scratched and punched V5 when giving care. V5 and V7 (CNA) were going to transfer to the reclining high back wheelchair using mechanical lift. V5 and V7 were on left side of bed (bed was against wall). R5 suddenly hit her hand against the bar while attempting to lift up. V7 was using the controller and V5 was standing near R5 holding 1 hand near the pad. V7 and V5 saw R5 hit her hand on the bar. R5 made loud noise. R5 was cooperative during the transfer until she hit her hand. R5 is supposed to have her hands across her chest

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S9999	Continued From page 19 during the transfer. Hands are placed across the chest for safety and to prevent injury. R5 can act out suddenly. R5 can be aggressive and unpredictable. The staff are responsible for keeping residents safe during transfers. On 4-15-22 at 10:39 AM, V6 (LPN) said R5 is alert, oriented x 1. R5 is not conversational and nonsensical due to her dementia. R5 can get agitated and change instantly. R5 would flail her arms and could possibly hit staff. V6 has seen R5 change instantly and have behaviors. V5 would assist with mechanical lift transfers using 2-person assist. One staff uses the controller after placing resident in the sling. The other person is there to guide and protect the resident's head and arms. Arms are to be crossed against the chest or belly. The crossed arms are for safety and to prevent injury. The guide must keep eyes on the whole time. If V6 saw the R5's arms go up, V6 would immediately redirect R5 to keep arms crossed. R5 requires close supervision during transfers. On 4-19-22 at 2:10 PM, V6 said the side rails should be down when transferring a resident from chair to be with the use of a mechanical lift. After the transfer, the staff should raise the side rails. On 4-15-22 at 10:22 AM, V7 (CNA) said R5 is demented and not alert. R5 is not directable. R5 can be agitated and irritated. R5 will flail her flail her arms when refusing care. R5 can be unpredictable. V7 has to be extra cautious and alert when providing R5 care. The facility uses 2 persons for mechanical lift (1 to control to machine. the other is to guide the resident) to ensures sure R5 is always safe. R5's arms should be on the chest for safety. The guide is responsible for making sure the arms are on the chest.	S9999		

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S9999	Continued From page 20 On 4-19-22 at 2:12 PM, V19 (restorative nurse) said siderails should be down when transferring a resident using the mechanical lift. The rails should be down to ensure a smooth transition or pathway from one surface to another surface. Progress Note dated 2-16-22 documents Incident Note Late Entry: Incident Summary: At approximately 5:30 am, this writer and another staff was using the mechanical lift with resident for transfer from bed to her wheelchair. During that process, resident became agitated and grabbed the mechanical lift bar and accidentally bumped her right hand on Hoyer lift bar sustaining a laceration to her right middle finger. Staff redirected resident, attempted to calm her down, and immediately lowered resident back in bed. Resident continued to be restless and moving around once in bed and accidentally bumped her left side of forehead against the side rail sustaining a laceration on her left forehead above the left eyebrow. Resident continued to be restless and pressure dressing applied to Left forehead laceration and Right middle finger to control bleeding. Paramedics called and transported resident to local hospital ER for evaluation and treatment. Nursing Supervisor notified. MD (Medical Doctor) on call for primary MD. POA(Power of Attorney/Daughter notified. Progress Note dated 2-16-22 documents Health Status Note Text: Resident transported to facility via stretcher from ER visit R/T to facial laceration and middle finger laceration. Arrived on the unit alert and awake, no change in LOC noted. Resident assessed noted with 4 sutures to left of forehead and swollen discolored right middle finger. Per discharge instruction sutures will dissolve over time. No facial grimacing or body guarding. NP (Nurse Practitioner) of primary MD	S9999		

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assessed resident and order STAT X-Ray of right middle finger due x-ray was not done in ER (Emergency Room). Order noted and carried out. POA notified of resident's return to facility and x-ray order. Progress Note dated 2-16-22 documents Health Status Note: X-Ray result of Right Middle finger concluded Comminuted fracture in the distal phalanx of the 3rd digit. Result review by NP of primary Dr. MD. NP (Nurse Practitioner) placed splint to resident's finger. Resident stated, 'I have pain there, there, PRN acetaminophen 650 mg PO (by mouth) offered, resident spitted medication from mouth.

Initial State Reportable dated 2-16-22 documents R5 was transferred from her bed to her wheelchair by the nurse on duty and another staff using a mechanical lift. During transfer, R5 became agitated and grabbed the mechanical lift bar and accidentally bumped her right hand sustaining a laceration to her right middle finger. Staff immediately lowered R5 back to bed using mechanical lift. Staff redirected R5 and attempted multiple times to calm her down, but resident remained uncooperative and talking nonsensical. After R5 was transferred back to bed, R5 continued to move around and accidentally bumped her left side of forehead against the siderail sustaining a laceration on her left forehead. R5 had head to toe assessment and staff treated wounds. R5 was sent to local hospital for evaluation and returned with sutures to her left forehead and right middle finger covered with bandage. Final State Reportable dated 2-21-22 documents Conclusion: R5 grabbed the mechanical lift bar during transfer from bed to wheelchair and accidentally bumped her right hand sustaining a laceration to her right middle finger. R5 continued to move her head and accidentally bumped the left side of her

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forehead against the right siderail of the bed sustaining a laceration on her left forehead with minimal bleeding.

Hospital Record dated 2-16-22 documents History: R5 presents with laceration to right middle finger and left eyebrow from nursing home, occurred on mechanical lift at the home. R5 is demented and unreliable historian. Triage: R5 presents with 2 CM laceration on the finger and 4 CM (centimeter) laceration on the left eyebrow. Number of sutures: 4 in face, 3 in finger. There is no documentation of x-rays taken or concerns of fracture in hospital record.

Mechanical Lift Transfers Policy dated 7-28-21 documents prompt resident to fold arms on chest. Portable Patient Lift Owner's Guide documents keep all extremities (such as fingers and arms) clear of left mechanism while it is in operation. Care must be taken to avoid pinch points when the lift is being operated. Side Rail Care Plan (revised 2-16-22) documents Please lower my siderail before transfers. Side Rail Policy reviewed on 7-28-21 was reviewed.

R5's MDS (ARD ((Assessment Reference Date) 2-4-22) documents BIMS (Brief Interview for Mental Status)score: 3:15, Transfer: Self: total dependence, Support: 2+ person physical assistance, Diagnoses (not limited to): Alzheimer's Disease, Non-Alzheimer's Dementia, Depression, Schizophrenia.

R8

On 4-14-22 at 12:45 PM, R8 was up to her reclining high back wheelchair in the dining room. R8 is confused and unable to carry a meaningful conversation with surveyor. Surveyor noted scab

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S9999	Continued From page 23 to R8's forehead. On 4-19-22 at 11:45 AM, V3 (Director of Nursing/DON) said R8's nurse notified V3 of fall incident. V3 instructed to give 1st aid, immediate interventions, and call 911 due to head injury (noted bleed). R8 returned around 4:50 PM with stitches on forehead. Investigation findings document R8 is impulsive and suddenly stood up and resulted in a fall with head injury. CNA was present and unable to prevent fall. R8 is oriented x 1 with dementia. R8 has impulsive behavior and poor safety awareness. R8 requires 1-person direct supervision in shower. Prior to incident (1-28-22) and after incident (3-26-22) R8 is coded as high fall risk. On 4-19-22 at 10:52 AM, V6 (LPN) said is alert and oriented x 1. R8 is not able to make her needs known due to dementia. R8 requires supervision due to poor safety awareness. R8 is impulsive and would try to do things by herself. R8 will attempt to get up from wheelchair by herself and without asking. R8 requires 1 person assist for showers. Staff must guide and direct R8 during showers. CNA reported fall to V6. V6 went to assess R8 and R8 was up to the wheelchair with head bandaged and bleeding controlled. R8 complained of pain to her head. R8 grimaced and flinched when V6 was assessing her head. R8 was unable to say what happened. CNA said R8 was in shower chair and had an immediate bowel movement, CNA pivoted to get disposable brief, and observed R8 on the floor with immediate head injury. R8 requires 1:1 supervision and needs direct attention. On 4-19-22 at 11:09 AM, V24 (CNA) said R8 is verbal, nonsensical, and unable to make her needs known. R8 is a fall risk. R8 has dementia.	S9999		

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S9999	Continued From page 24 R8 is impulsive and will try to get up. V24 took R8 to resident to shower. R8 had a bowel movement during the shower. V24 said he turned to his side to pick up a brief and R8 suddenly fell. R8 was facing down on the ground and V24 saw blood on R8's forehead. R8 requires 1:1 attention during showers. Initial Incident Report dated 3-26-22 documents CNA was giving R8 a shower. CNA turned to get R8's disposable brief, R8 suddenly got up and observed on the floor in the prone position. Nurse immediately responded and observed R8 with laceration on her forehead with minimal bleeding on forehead. MD updated and ordered to send to hospital via 911. Later that day, R8 arrived back at facility with stitches on forehead. Final Reportable dated 3-31-22 documents R8 has poor safety awareness related to vascular dementia with behavior disturbance, she suddenly stood up which resulted into fall. CNA was unable to stop the fall. Final Reportable dated 3-31-22 documents R8 has poor safety awareness related to vascular dementia with behavior disturbance, she suddenly stood up which resulted into fall. CNA was unable to stop the fall. Fall Risk Evaluation dated 1-28-22 documents score: 12 and Fall Risk Evaluation dated 3-26-22 documents score: 12 (8 and above = high risk), Fall Prevention Program Guidelines reviewed 8-5-21 documents residents shall be observed to ensure the resident is safely positioned in bed or chair. Provide care as assigned in accordance with the plan of care. R8's MDS (ARD 4-4-22) documents BIMS Score 3, Diagnoses: Non-Alzheimer's dementia, Osteoporosis, Other Fracture, Need for assist with personal care. Fall Risk Evaluation dated	S9999		

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WARREN BARR LIEBERMAN	9700 GROSS POINT ROAD SKOKIE, IL 60076

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S9999	Continued From page 25 1-28-22 documents score: 12 and Fall Risk Evaluation dated 3-26-22 documents score: 12 (8 and above = high risk), R8's Fall Care Plan documents Fall Prevention Program Guidelines reviewed 8-5-21 documents residents shall be observed to ensure the resident is safely positioned in bed or chair. Provide care as assigned in accordance with the plan of care. Hospital Record dated 3-26-22 documents History: Patient presents with FALL. History of Present Illness: Per report, patient with witnessed fall out of wheelchair this morning. Struck front of face. Procedure: Laceration Repair. Number of sutures: 6. (A)	S9999		