STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013213	A. BUILDING: _____ B. WING _____	C 10/24/2022

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LINCOLNWOOD PLACE	7000 NORTH MCCORMICK BLVD. LINCOLNWOOD, IL 60645

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S 000	Initial Comments Complaint Investigation: 2294867/IL148237 2295081/IL148502 2295392/IL148860 2296630/IL150346 2297748/IL151653 Facility Reported Incident of 06/25/2022/IL148847	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1010h) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations are not met as evidenced by: Based on interviews and record reviews, the facility failed to protect a resident from physical abuse during provision of care for one (R1) of five residents reviewed for abuse. This deficiency resulted in R1 feeling shocked and frustrated	S9999		

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S9999	Continued From page 2 after being slapped on the face and sustained a bruise on the right side of lip. Findings include: R1 is a 97 year old, female, admitted in the facility on 06/04/22 with diagnoses of Displaced Intertrochanteric Fracture of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing; Chronic Kidney Disease, Unspecified; Muscle Weakness (Generalized); Other Lack of Coordination and Age Related Cognitive Decline. According to progress notes dated 06/25/2022, R1 was found to have a bruise on the right side corner of her lips. R1 stated that a CNA (Certified Nurse Aide) was turning her in bed this morning during morning care and she (R1) screamed and CNA hit her right side of face. Facility's initial abuse incident report dated 06/25/22 documented that V2 (Director of Nursing) was informed that in the morning that CNA (Certified Nurse Aide) was turning from side to side during changing of incontinence brief, R1 screamed and CNA slapped her three times to the right side of her face. V5 (Agency CNA) was the CNA. On 10/18/22 at 2:00 PM, V5 was asked regarding incident on 06/25/22 with R1. V5 stated, "That day, the nurse (V21) told me to get her (R1) up that morning. I set up my morning rounds, so I was preparing her clothes and getting her ready. She was a little terrible, irritated. I got her dressed, started to behave nicer and talking like normal. As soon as she's done dressed, as I am about to transfer her to her wheelchair, she threw herself back into bed and said she does not want	S9999		

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S9999	Continued From page 3 to get up. Refusing to get up said she doesn't get up in the morning. She was screaming, hollering. I just assisted her back to bed. She was verbally aggressive to me but not physical. When that happens, I walk away from the situation. I told the nurse that she was screaming and does not want to get up. I didn't notice anything unusual to her skin or face, I wasn't paying attention. The nurses don't update CNAs regarding residents' behavior. V12 (CNA) told me that she (R1) was a screamer, combative because she usually does not want to get up in the morning." V21 (Registered Nurse, RN) was asked regarding R1 and incident on 06/25/22. V21 replied, "That day, V5 told me that she (R1) does not want to get up from bed. Nothing was told about her (R1) screaming or being combative when she was trying to get her up. I did not actually tell V5 to get her (R1) up from bed that morning. Cause I know exactly that she does not want to get up from bed, she prefers to get up after breakfast. She (R1) has a behavior of screaming like if she wants to talk to V22 (Family Member) and unable to, she screams. When she gets frustrated like she cannot reach for something, she screams. All staff were aware of her behavior. Try to talk to her, calm her down. She just screams, yell but not combative during care or will throw herself back to bed. When she is alone, she will just scream but nothing that would do harm to herself." On 10/19/22 at 11:35 AM, V12 (CNA) was also asked regarding R1 and behavior. V12 mentioned "She is alert, oriented, sometimes confused. She is a screamer, yells a lot. She starts screaming like six or seven in the morning, she just gets confused. She was not combative or resisting to any care. Sometimes, she gets anxious during	S9999		

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S9999	Continued From page 4 patient care in the morning. V5 asked me about R1, in general. I told her (V5) that she easily gets very anxious during care. I told her (V5) that you need to talk to her (R1), calm her (R1) down and report to the nurse regarding behavior. She (R1) does not do anything harmful to herself but screams. It depends on her mood whether she wants to get up in the morning, I talk to her (R1) and ask if she prefers to get up in the morning or right after breakfast. She does get a little uneasy, anxious when a staff wakes her up in the morning. She has a behavior monitoring log, I know I reported her behavior to the nurse every time she has it. R1's MDS (Minimum Data Set) dated 06/10/22 documented: Section C (Cognitive Patterns) - BIMS (Brief Interview for Mental Status) score 14 which means cognition has little to no impairment. Section D (Mood) - Behavioral Symptoms E0200 Behavioral Symptom - Presence and Frequency Physical Behavioral Symptoms directed toward others (e.g. hitting, kicking, pushing, scratching, grabbing, abusing others sexually): Behavior not exhibited. Verbal behavioral symptoms directed toward others (e.g. threatening others, screaming at others, cursing at others): Behavior not exhibited. Other behavioral symptoms not directed toward others (e.g. physical symptom such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). E0300 Overall Presence of Behavioral Symptoms - none E0800 Rejection of Care - Presence and Frequency - behavior not exhibited	S9999		

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S9999	Continued From page 5 R1'S Psychiatric Evaluation dated 06/13/22 documented: History of Present Illness: Upon interview, she presents somewhat anxious. She tends to become calmer when being talked to, but when left alone she could be observed making noise. She manifests feelings of helplessness due to her situation. She gets upset when her needs are not immediately met. She complains of some difficulty of sleeping, which appears to be related to her discomfort. She denies overt hopelessness. She does not endorse any suicidal ideations or plans. She does not present with any overt paranoia or psychosis. Assessment: Adjustment reaction with depressive symptoms/acute pain/mild cognitive impairment. Behavior monitoring logs dated June to September 2022 indicated that R1 does not exhibit any behavior most of the time but yells/screams on the following dates: 06/18/22 - 3 (yelling, screaming) 08/03/22 - 0 (frequent crying); 3 (yelling, screaming) 08/09/22 - 3 (yelling, screaming) 08/25/022 - 3 (yelling, screaming) R1's care plan regarding mood problem as exhibited by: verbal expression (s) of distress; anxious appearance: Interventions - Monitor/record/report to MD (medical doctor) PRN (when necessary) mood patterns signs and symptoms of depression, anxiety, sad mood as per facility behavior monitoring protocols. There were no other interventions addressing behavior of screaming and yelling. On 10/19/22 at 2:20 PM, V2 (Director of Nursing) was interviewed regarding incident on 06/25/22	S9999		

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S9999	Continued From page 6 between R1 and V5. V2 stated, "I was the one who investigated R1's incident last 06/25/2022. I got a call from the nurse stating that V22 reported that she (R1) had an incident with V5 from the morning. She (R1) stated that V5 slapped her three times in the face while giving care. I came in and spoke to her (R1) and asked her what happened. She said she was not able to recall what happen but V5 was turning her side to side to change her incontinence brief, she (R1) was screaming and resisting to care. V5 continued to change her while she was screaming and resisting to care. I asked if she (V5) was mean or hit her in any way. She (R1) did not mention about slapping. I did assess her (R1), she had a bruise on the corner of the lip on the right side. There was an injury on the lips. I asked her (R1) about the bruise and said she does not remember. According to V5, she went to change her (R1) and she (R1) was screaming while she is being cared for. She (R1) was resisting to care. So she (V5) called another staff to guide her and was told not get her (R1) up during breakfast so she helped her (R1) back to bed. I asked V5 about slapping, said she (V5) did not slap her (R1) and did not notice any bruising on her face. I don't know how the resident got the bruise. The resident did not remember and V5 said she did not notice any bruise during care. I did investigate about the bruise but I don't have the documentation. If a resident is screaming and combative/resisting to care, CNA should stop providing care and let the nurse know and come back later. Make sure the patient is safe. Prior to the incident, I was not aware that she does not want to get up for breakfast. I was also not aware that she has a behavior of screaming. I don't have any care plans for the behavior. Reviewing V5's statements during interview and	S9999		

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S9999	Continued From page 7 V2's investigation, discrepancy was noted. V5 stated that when she was about to transfer her (R1) to her wheelchair, she threw herself back into bed, saying she does not want to get up. That she (R1) was screaming, hollering, so V5 assisted her back to bed and walk away from the situation. She (V5) told the nurse (V21) that she (R1) was screaming and does not want to get up. However, V21 mentioned that she (V5) did not tell her about R1's screaming or being combative when she (V5) was trying to get her (R1) up. While V2's investigation stating that when V5 was turning her (R1) side to side to change her incontinence brief, she (R1) was screaming and resisting to care but V5 continued to change her (R1). On 10/20/22 at 12:07 PM, R1 was called and interviewed on what really happened on 06/25/22 with V5. R1 recalled, "I can't remember the date, the CNA (referring to V5) apparently wants me to do something. I think I cannot respond to her demand. She was very demanding to me to do it. We were standing facing one another. Then she wants me to do something which I can't respond, I got anxious and scream and she slapped me on the right cheek, bottom of face. It did turn black and blue. I was shocked. I called V22 at home. I told V22 about what happened. I was in a state of shock, dumbfounded. I was shocked because somebody I don't know hit me and she was employed by the facility. She is supposed to take care of me." V5 stated in an interview that when she was about to transfer R1 to her wheelchair, she threw herself back into bed and said she does not want to get up, screaming, hollering. R1 stated she was standing, facing V5 when she (V5) asked her (R1) to do something which she cannot respond,	S9999		

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S9999	Continued From page 8 made her (R1) more anxious and scream, which led V5 to slap her. Therefore, R1's screaming did not happen during incontinence care. Facility did not conduct a thorough investigation on the abuse incident between R1 and V5. There were discrepancies with the abuse report versus statements from V5 and R1. V22 was asked regarding the said incident between R1 and V5. V22 stated, "I visited her (R1) that afternoon, around lunch time, I saw a bruise in the corner of her mouth. She (R1) told me that she was hit by the CNA into the mouth three times to quiet her down because she was screaming. I was shocked when she told me that. She was never manhandled with someone working in the facility." R1's Change in Condition Follow Up documentation dated 06/25/22 documented: A. Complaint - right lip bruise. Facility's final abuse report dated 06/30/22 did not include any investigation on how R1 got the bruise on her lip. There were no documentation pertaining to the investigation of R1's bruise on her right lip and no report was made to local state agency. On 10/20/22 at 2:59 PM, V25 (Physician) was asked regarding her expectations on staff regarding abuse. V25 verbalized, "I expect all nursing home residents are cared for with kindness and compassion. I would never expect any abuse from staff to residents. Everybody should be treated with respect and compassion." Facility's policy titled "Abuse and Neglect Reporting Policy Including Suspected/Confirmed Resident-Resident Abuse" reviewed date	S9999		

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S9999	Continued From page 9 03/04/2022 stated in part but not limited to the following: Policy: Unless otherwise specified by state regulations. It is the policy of (name of company) to ensure that all reporting of abuse and neglect is handles in accordance with state rules and regulations. This policy will ensure that proper reporting procedures are followed when a case of abuse, neglect, or exploitation is reported. Prevention - Protection The Abuse policies and procedures of this community are developed to promote a safe living environment for all residents. Residents must not be subjected to abuse, neglect, or mistreatment by anyone, including, but not limited to facility or agency staff, other residents, family members or other visitors. Prevention of abuse/neglect requires the involvement of all staff to monitor, observe, intervene and report any behaviors/ situations that may lead to conflict or neglect. (B) Statement of Licensure Violations (2 of 2) 300.610a) 300.1010h) 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 administrator, the advisory physician or the	S9999		

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S9999	Continued From page 10 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 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. 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:	S9999		

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S9999	Continued From page 11 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 are not met as evidenced by: Based on observation, interview, and record review the facility failed to follow their policy and procedure for fall prevention by not completing a comprehensive fall care plan, not identifying necessary fall interventions, not accurately completing fall assessments, not having the necessary amount of staff to provide care for a resident who required two person staff assistance with bed mobility and transfers for three of six residents (R4, R6, and R10) reviewed for accidents/injuries. This failure resulted in R4 having a fall that resulted in a fracture. Findings include: 1. R4 is a 90-year-old male with a history of Parkinson's Disease (Present on Admission 03/20/2021), Dementia without Behavioral Disturbance, Alzheimer's Disease, History of Falling, Abnormalities of Gait and Mobility, Lack of Coordination, and Dysphagia who was originally admitted to the nursing facility 2/8/2018. R4's progress note dated 6/9/2021 9:04 PM (21:04) documents Chief Complaint includes Deficits in Mobility and Self Care Skills, History of Present Illness: 88-year-old male admitted to the Hospital after an unwitnessed fall and altered mental status. In the emergency room the patient had an episode of weakness on one side as well as acute mental status changes, code stroke was	S9999		

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S9999	Continued From page 12 initiated. The patient was stabilized medically and admitted to nursing facility for subacute rehab therapies, for muscle weakness and deconditioning. R4's fall risk assessment dated 03/20/2021 documents he has a score of 8 and is at low risk for falls; and records him to be receiving 1-2 medications including Anesthetics, Anti-histamines, Antihypertensives, Antiseizure, Benzodiazepines, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Sedatives/Hypnotics currently or within the last 7 days. R4's most current physician order sheet documents active orders as of 03/20/2021 for more than two medications considered in the fall risk review assessment including antihypertensives, hypoglycemics, and psychotropics. R4's fall risk assessment dated 05/02/2021 documents he has a score of 8 and is at low risk for falls; and records him to have no predisposing diseases present such as Parkinson's. R4's Discharge Summary dated 08/02/2021 documents he was sent to the hospital via emergency medical services related to a fall and was admitted to the hospital with a diagnosis of broken left femoral neck fracture. Director of Nursing and Physician made aware. R4's most current care plan reviewed 10/19/2022 documents he is at risk for falls related to Confusion, Deconditioning, Gait/balance problems, Incontinence, Psychoactive drug use, history fall, dementia, Alzheimer with interventions including: R4 needs a safe	S9999		

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S9999	Continued From page 13 environment with: (even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low Position; Follow facility fall protocol; Ensure that R4 is wearing appropriate footwear - non skids socks, shoes when ambulating or mobilizing in wheelchair. R4's Hospital Record dated 08/02/2021 documents he lived at the facility and was admitted through the emergency department after a fall and sustained a left femoral neck fracture that will require surgical repair. Written incident report dated 08/02/2021 documents R4 experienced an unwitnessed fall at 1:30PM and was unable to explain what happened due to cognition and language barrier; R4 was using a wheel chair at the time of the incident; During rounds at 7AM, R4 was still in bed, at 8AM he was in the dining room for breakfast, at approximately 9:50AM administered medication to R4 and R4 was in the television room and participated in activities; at approximately noon R4 was brought to the dining room then to the television room after lunch; at approximately 1:20PM heard a scream In the television room while at the nurses station and upon getting up to check observed R4 in left sideline position on the floor with head not touching the floor and raised up; no loss of consciousness or apparent injury noted. R4's Incident investigation report dated 08/03/2022 documents on 08/02/2021 at around 1:30PM the nurse heard a loud sound in the living room and immediately ran to assess the situation, R4 was observed on the floor in front of his wheelchair, on his left side; R4 was sent to the emergency room for further evaluation per	S9999		

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	IL6013213	A. BUILDING: _____ B. WING _____	C 10/24/2022

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S9999	Continued From page 14 physician's orders; report received from the hospital 08/02/2021 around 8PM documented R4 sustained a left femoral neck fracture and was admitted to the hospital for further treatment and remains in the hospital at this time; R4 is a pleasant man with past medical history of Alzheimer's Dementia, Parkinson's Disease, Muscle Weakness, and Lack of Coordination, and Transient Strokes who has a tendency to get up without asking for help due to his impulsivity. Certified Nursing Assistant Occurrence Report Statement dated 08/02/2021 included with incident report documents regarding R4's fall incident at 1:30PM V7 (Certified Nursing Assistant) reported R4 was sitting in the television room after lunch and fell about 1:30PM. V7 reported she had been with other patients and when she was finished, she observed the nurse with R4. On 10/19/2022 at 12:22PM V16 (Family Member) reported R4 has Alzheimer's, and needed supervision because he can't recall things. V16 report she believes R4 would attempt to get out of his chair without assistance because when he was home with her and their family they had to watch him all the time because he would try to eat things even if they weren't actually food. V16 stated R4 needed constant supervision. 2. R10 is a 77-year-old female with a diagnoses history of Contusion of Head Subsequent Encounter, Morbid Obesity, Peripheral Vascular Disease, Polyosteoarthritis, and Dependence on Other Enabling Machines and Devices who was originally admitted to the facility 8/5/2022. On 10/18/2022 from 12:47 PM - 1:24 PM,	S9999		

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S9999	Continued From page 15 Observed R10 sitting in the television room in her wheelchair being served lunch. Observed R10 with bruises on her forehead, near temple, and underneath her left eye. R10 stated she experienced a fall as a result of a Certified Nursing Assistant (CNA) raising her out of her bed with her bed sheet. R10 stated she told the Certified Nursing Assistant multiple times that she requires at least two CNA's for transferring her and the CNA insisted she was strong enough and could do it by herself. R10 stated the CNA then snatched her sheet from underneath her which caused her to fall and hit her head on the table and floor. R10 stated she tried grabbing the nightstand when she was falling. R10 stated her roommate was present during the incident but won't likely be able to report anything because of her mental status. R10 stated she was sent to the hospital after the incident. R10 stated she was afraid she had cracked her skull and asked to go to the hospital. R10 stated she also injured her toes when she fell. R10's current care plan reviewed 10/19/2022 documents she is High, risk for falls related to use of diuretics, hypoglycemic, psychotropic and antihypertensive medications, other diagnoses including Peripheral Vascular Disease, Atrial Fibrillation with interventions including: Anticipate and meet the resident's needs; 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 requests for assistance; Follow facility fall protocol; Care plan initiated 09/11/2022 documents R10 has had an actual fall with minor injury, with interventions including: Monitor/document /report as needed for 72 hours, report to physician signs and symptoms of: Pain, bruises, Change in mental status, New onset:	S9999		

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S9999	Continued From page 16 confusion, sleepiness, inability to maintain posture, agitation. R10's fall assessment dated 08/05/2022 documents she has a score of 11 and is at high risk for falls. R10's admission minimum data set dated 08/11/2022 documents she requires extensive 2-person assistance with transfers from bed, chair, wheelchair, standing position; requires extensive 2-person assistance with bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture). R10's progress note dated 9/11/2022 7:10 PM (19:10) documents: resident had assisted fall at 7-3 shift and was transferred to the Hospital via ambulance as ordered by physician. Nurse made a follow-up on resident's status. Informed by at Hospital that resident was admitted with initial diagnosis of atrial fibrillation. R10's hospital record dated 09/11/2022 documents she was received from the nursing home after a fall and was unable to recall the incident; per history she was being assisted to the restroom and slipped. Incident Investigation Report dated 09/11/2022 documents at 12:30 PM, R10 was witnessed to experience a fall and reported the reason she fell was because "my knees gave way,"; she was noted to be using a wheelchair during the incident and while being assisted by a Certified Nursing Assistant (CNA) her knees buckled and she was assisted down to the floor. Certified Nursing Assistant Occurrence Report	S9999		

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S9999	Continued From page 17 Statement dated 09/11/2022 included with incident report documents regarding R10's fall incident at 12:30 PM, V15 (Agency Certified Nursing Assistant) reported she transported R10 to the bathroom using sit to stand equipment and while attempting to transfer R10 from the bathroom after toileting to put a diaper on her she noticed R10 was "going down,"; V15 reported she began shouting for help but no one came to assist; V15 reported she ran out and started shouting before seeing a therapist who followed her back to R10's room. V15 reported upon returning to the room she and the therapist immediately began releasing R10's hand from the sling and she sat on the floor. V15 reported she noticed R10 was short of breath and laid her down and began administering oxygen; V23 (Physical Therapist) reported while in another room treating a patient, the physical therapist heard a CNA yelling for assistance. V23 reported they came to assist because the CNA couldn't find anyone at the time. V23 reported upon initially seeing R10 during this incident she was already lowered to the floor in a seated position by the mechanical lift. V23 reported not observing what occurred prior to this and once R10 was safely positioned and confirmed not to be in distress or unconscious, the therapist ran to alert the lead nurses for assistance. V23 reported the lead nurse contacted the emergency department. R10's fall risk assessments dated 09/30/2022 and 10/04/2022 documents she had no falls in in the past 3 months. R10's Hospital Report 10/04/2022 documents she reports she fell on her left side hitting the side of her head while she was being rolled over for a bed sheet change; observed with left forehead swelling, x-ray scan performed for head	S9999		

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S9999	Continued From page 18 contusion; nursing home notified of fall incident R10 sustained local injury to the left side of the head with hematoma; post fall sustained local forehead injury. R10's Incident Report dated 10/04/2022 documents she experienced a witnessed fall at 5:20AM from her bed; R10 reported the fall happened "because I was turning on my side."; V13 (Licensed Practical Nurse) reported during rounds she heard a certified nursing assistant call out for help from the next room, as she entered R10's room she observed R10 on the floor face down next to her bed. When she asked R10 what happened the certified nursing assistant explained she was changing R10 and she rolled on her side, the resident kicked her feet over and fell out of the bed. R10 reported to V13 that she hit her head. V13 observed a raised area on the left side of R10's scalp and notified the physician. The physician ordered R10 be sent to the hospital and R10 was transferred to the hospital. Certified Nursing Assistant Occurrence Report Statement dated 10/04/2022 included with incident report documents regarding R10's fall incident at 5:29 AM, V14 (Certified Nursing Assistant) reported while in R10's room changing her diaper the resident lifted her left leg over her right and the momentum made both her legs fall out of the bed; V14 reported she tried to grab R10's legs and it was too late and her body had fallen out of the bed and hit the cabinet and the floor. On 10/19/2022 at 10:00 AM, Observed R10 in her room lying in her bed with her call light attached to her bed. Observed R10 crying. R10 stated she overheard two staff laughing stating she rolled herself out of bed when she fell. R10 stated why	S9999		

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S9999	Continued From page 19 would she hurt herself like that. R10 stated "look at all these bruises and knots on my head." Observed R10 with multiple bruises on her forehead and under her eye and a raised area on her forehead. R10 stated nobody believes her. R10 stated her injuries came from when a Certified Nursing Assistant raised the sheet from under her and caused her to fall and hit her head. R10 stated she was given the bed she is in now that is a larger bed with wings on each side to prevent her from rolling out of bed because they believe she rolled herself out of bed and won't believe her. On 10/19/2022 at 1:03 PM, V2 (Director of Nursing) stated if a fall assessment is not filled out correctly it may affect the resident's care by not having supervision and interventions in place for them as needed. V2 stated based R4's incident investigation report dated 08/03/2022 he required constant supervision. V2 stated R4 should have been closely monitored during his fall incident. V2 stated supervision should have been included in R4's fall care plan. V2 stated R10 should be assisted by two Certified Nursing Assistants (CNA) for transfers, and this should be included in her care plan in order for the certified nursing assistants to be aware of this need. V2 stated she is not sure why there was only one CNA assisting R10 with transferring from the toilet on 09/11/2022 and while being changed on 10/04/2022. V2 stated there has not been any issues with having enough staff to care for the residents and possibly the other available CNA's were assisting other residents during R10's incidents. On 10/19/2022 at 2:10 PM, R10 stated after the incident of falling as a result of the Certified Nursing Assistant pulling her sheet from	S9999		

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S9999	Continued From page 20 underneath her, she was fearful whenever the CNA's would attempt to move her and didn't feel as safe when being repositioned or transferred. On 10/20/2022 at 11:39 AM, V11 (Licensed Practical Nurse) stated R10 requires two person assistance. V11 stated on 09/11/2022 when R10 was transferred from her bed to her wheelchair there were two Certified Nursing Assistants (CNA) assisting. V11 stated however, when R10 was being transferred from the toilet back to her wheelchair there was only one CNA who performed this activity. V11 stated during that time that CNA used the sit to stand equipment to assist R10 and she was not aware the CNA was performing this activity by herself because she had informed the CNA that R10 required two-person assistance for transfers. The facility's Fall Policy received 10/20/2022 states: "The facility is committed to minimizing resident falls and/or injury and to maximizing each resident's physical, mental and psychosocial well-being. While preventing all resident falls is not possible, the community will act in a proactive manner to identify and assess those residents who are at risk for falls, plan for preventative strategies and facilitate a safe environment." "All care staff will be responsible in assisting with the implementation of the community's Fall Management Program to maintain the safety of all residents in the community. The program will include measures which determine the individual needs of each resident by evaluating the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices as necessary."	S9999		

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S9999	Continued From page 21 3. R6 is a 94 year old male admitted to the facility 6/23/22 with diagnoses that include hemiplegia and hemiparesis affecting the left side, blindness following cerebral infarction, and dementia. R6 was assessed on 9/28/22 to have mild cognitive dysfunction with a BIMS of 10. R6 functional assessment indicates that he requires extensive one person physical assistance with all activities of daily living and uses a walker and wheelchair for mobility. R6 was admitted to the facility after sustaining a fall at home and upon admission was assessed on 6/23/22 as being a high fall risk with a score of 14. R6 suffered a fall while in his room on 7/10/22, sustained a laceration to the left forearm and was sent to the hospital for evaluation with no further orders upon return to the facility. On 10/17/22 at 1:41 PM, R6 was observed in bed, alert and oriented to person with confusion. R6 is not on isolation and has a roommate who is alert and able to make needs known. R6's bed was noted to be in a low position in relation to the floor and had a cushioned floor mat on each side of the bed. Call light was within reach. The facility was unable to provide an initial or current care plan for fall prevention. Post Fall investigation for R6 dated 7/10/22 was reviewed. DON reviewed and signed this investigation on 8/06/22 and on review noted that R6's fall may have been caused by the resident being impulsive. The assessment asks, "what interventions were previously in place?" to which the DON answered N/A and goes on to indicate that new interventions placed will include having the bed in the lowest position with floor mats.	S9999		

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S9999	Continued From page 22 (A)	S9999		