PRINTED: 02/07/2023
FORM APPROVED

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
	IL6007751	A. BUILDING: ____ B. WING ____	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED BUD REGIONAL CARE	350 WEST SOUTH 1ST STREET RED BUD, IL 62278

(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 and Certification	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3)6) 300.1220b)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 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.	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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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.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

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These Regulations are not met as evidenced by:

Based interview and record review, the facility failed to assess/monitor and identify potential injury after a fall which delayed treatment for 1 of 11 residents (R40) reviewed for quality of care in the sample of 31. The facility also failed to provide safe transfer techniques and implement progressive fall interventions to prevent falls in 2 of 11 residents (R40, R160) reviewed for falls in the sample of 31. These failures resulted in R40 experiencing a decline in physical therapy status, requiring pain medications and delaying the treatment for a right hip fracture requiring surgical repair and R160 falling and sustaining a laceration to head requiring 8 staples.

Findings include:

R40's Face Sheet documents R40 was admitted to the facility on 1/5/21 and has diagnoses including type 2 diabetes mellitus without complications, chronic systolic (congestive) heart failure, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, and unspecified fracture of right femur, initial encounter for closed fracture.

R40's Minimum Data Set (MDS) dated 12/15/2021 documents R40 is severely cognitively impaired, requires extensive 2+/plus person assistance with bed mobility and transfer, and activity of walking did not occur during previous 7-day period.

R40's Fall Risk Assessment dated 12/15/21

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documents R40 is at high risk for falls.

R40's Care Plan dated 12/15/21 documents, "Risk for falls r/t (related to) gait/balance problems, R (right) hemiplegia, unaware of safety needs, impulsive." The Care Plan does not address R40's transfer status.

R40's Physician's Order Sheet (POS), dated 1/5/2021 documents Tylenol give 650 milligrams (mg) by mouth every 6 hours as needed for chronic pain.

R40's Restorative Monthly Summary, dated 2/28/2022 at 9:19 AM documents "Resident continues to participate in restorative programs of bed mobility, PROM (passive range of motion) (right side extremities) and splinting (right hand). He requires assist of one for bed mobility. He has a splint to his right hand that is removed during the day for hygiene and off at HS (at bedtime). Resident attends physical rehab three days for conditioning and ROM (range of motion.)"

R40's Physical Therapy Daily Note, dated 3/4/2022, written by V16, Physical Therapy Assistant (PTA) documents "Patient tasked with pivot transfers from L/R (left/right) with use of grab bar (to stimulate toilet transfers.) Patient able to transfer with a minimum of two staff members, in both directions. Patient requires cues for weight shifting and foot placement. Patient also sidestepping at grab bar with minimum assist of two staff members (and wheelchair behind him for safety.) Patient sidesteps 7-foot x 1 foot to the left and 2-foot x 1 foot to the right. "

R40's Therapy Daily Note, dated 3/4/2022, written by Certified Occupational Therapy Assistant V17,

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(COTA) documents, "Patient participated in LUE (lower upper extremities) lateral pull down 2x 3 minutes to increase strength to improve IND (independent) with functional transfers with grab bars. Patient completed transfer training with front grab bar to stand and turn to his left to sit in the chair to simulate toilet transfers, patient then transferred back to his wheelchair to his right and patient required min (minimum) A (assist) x2 for balance. Lastly, patient completed side stepping at front grab bar with MOD (moderate) A x2 for balance and extra time to advance RLE (right lower extremity) x 10 feet, activity intend to increase IND with weight shifting to promote IND with toilet transfers." The Note documented R40 had 27 minutes of PT this day.

R40's Nurse's Note, dated 3/4/2022 at 7:12 PM documents, "This nurse was alerted by staff at 2:50 PM this shift, that resident had fallen. This nurse with other staff went to resident in dining room. Staff was attempting to transfer resident to weight chair to weigh and resident knees buckled, staff attempted to assist resident to floor and also fell to floor as well. No injury noted to staff or resident. This nurse assessed resident and VS (vital signs) taken. No injury noted to staff or resident. BP (blood pressure) rechecked at 162/72. POA (Power of Attorney) made aware."

The Facility's Incident Report documents R40 had fall on 3/4/22 resulting in hip fracture and hospitalization with surgery.

R40's "Incident Report" dated 3/5/22 at 2:50 PM documents, Pt (patient) c/o (complained of) increased pain on Monday, 3/8/22. Stat X-RAY showed fx (fracture) requiring hospitalization for surgical repair. Investigation shows gait belt not in use, one person transfer when order for

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two-person transfer."

R40's Physical Therapy (PT) Daily Treatment Note, dated 3/7/2022 written by V16 documents "Patient had a recent fall. Patient has difficulty with verbal communication, so it is difficult for patient's needs to be known. PTA attempts to have patient stand at grab bar with 2 assists as well as initiate pivot transfers - however, patient is not agreeable to this. Patient refuses to lean forward at grab bar. Patient is resistive to standing or transfer on this date. This is not typical of this patient. Patient is given time to rest and instructed in seated LE ex. Pt tolerates seated ex to increase strength for greater ease with standing, and transfers. ABD (abduction) and ADD (adduction) 25 reps each."

There was no documentation in R40's Progress Note related to V16 telling nursing department that R40's had atypical physical therapy session.

R40's Occupational Therapy (OT) Daily Treatment Note, dated 3/7/2022, written by V17 documents, "Staff report patient fell 3/4/2022 later in the afternoon when transferring with assist of one of CNA to weight chair with no gait belt. Patient's assist level has not changed which is assist of two for safety. When in therapy gym, patient refused to stand at front grab bar. When encouraged to transfer to recumbent bike for physical therapy, patient once again refused various times. Although non agreeable to standing training patient was agreeable to seated arm bike with LUE (left upper extremity) only at his own pace x10 minutes with occasional verbal encouragement and close supervision. Patient then completed LUE lateral pull down pulley's 2x 3 minutes, exercises intended to increase strength and endurance to decrease caregiver

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burden during functional transfers. Patient had little motivation for therapy this date, which is out of the ordinary of patient, patient was taken to activity in dining room with other residents." There was no documentation in this note that V17 assessed R40 for pain or if nursing was notified of the change in therapy status.

There was no documentation in R40's Progress Notes that V16 or V17 notified nursing of the change in R40's therapy status the morning of 3/7/22.

On 1/6/2022 at 11:30 AM, V17, stated, "We always follow residents in the morning. If he had fallen before we would put in a note. He was not agreeable to do the same thing as 3/4/2022 on 3/7/2022 but sometimes he does just stop during therapy. (R40) cannot verbalize pain, but I don't remember if he was showing any other signs of pain like grimacing. He might have groaned, but that is not out of the ordinary for him. I would have put in my note if he was in pain, but it is hard to tell when they can't come out and say it."

R40's Nurse's Note, dated 3/7/2022 at 5:40 PM, "This nurse also noted edema noted to resident right lower leg brought to this nurse's attention by wife. Exchange office called to update."

There was no documentation V9 responded to the facility regarding the call to the physician's exchange.

On 1/6/2022 at 1:00 PM, V8 Licensed Practical Nurse (LPN) stated she recalled R40 had high blood sugars on 3/7/2022 and she notified the provider of it and administered additional medication to treat the high blood sugar. She also recalled R40's family notified her that his right leg

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S9999	Continued From page 8 had edema. V8 stated she assessed R40's right lower leg as he sat in the wheelchair, she did not do range of motion on R40's lower extremities at that time. V8 stated she called the provider (physician) to notify them of the right leg edema, but she left the facility at 6:30 PM that shift, and no provider called her back. V8 stated if a provider called back, she would have documented what they said. R40's Nurse's Note, dated 3/8/2022 at 5:06 AM documents R40's right leg remains edematous, R40 had no signs or symptoms of distress or discomfort noted, call light within reach, and will continue to observe. This Note was written by V19, Licensed Practical Nurse (LPN). On 1/6/2023 at 11:00 AM V19 stated, "I work night shift 6:00 PM through 6:00 AM and was assigned to (R40) on 3/7/2022 into 3/8/2022." V19 recalled the night shift CNA reported R40's right hip looked "different". V19 stated she assessed R40 for pain, but she didn't assess his right hip at that time, and she didn't know why she didn't assess him. V19 stated R40 can't communicate verbally but she noted he had facial grimacing at that time. V19 stated she administered PRN pain medication and reported it to the oncoming day shift nurse. She stated didn't notify the provider; she thought the day shift nurse would. On 1/6/2023 at 11:48 AM, V18 night shift Certified Nursing Assistant (CNA) stated, she provided incontinence care for R40 around 5:00 AM on the morning of 3/8/2022, she noted R40's right hip didn't look right and described it as bigger than the left hip. V18 states she reported the concern to V19 immediately, but she didn't know if V19 assessed R40.	S9999		

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R40's Electronic Medication Administration Record (eMAR) note, dated 3/8/2022 at 5:28 AM, written by V19, LPN documents, "Tylenol 650 mg every 6 hours as needed for chronic pain was administered for elevated temp 100.8 degrees."

R40's Nurse's Note, dated 3/8/2022 at 7:25 AM documents, "Staff made this nurse aware this AM that res (resident) had swelling to right hip, upon assessing resident area is greater in size compared to left. Call made to exchange NP (nurse practitioner) called this nurse back with order for STAT (immediately) x-ray to right hip."

R40's Physician's Order Sheet (POS) dated 3/8/2022 documents STAT x-ray to right hip for swelling.

R40's (Hospital) "Imaging Report" dated 3/8/22 at 7:44 AM documents, "Exam Description: XR (X-Ray) Hip Unilat (Unilateral) 2V+ (Two View). Exam Reason: Swelling to Right Hip. Examination: AP (front to back) and frog leg (a special radiograph of the pelvis to evaluate the hip) lateral radiographs of the right hip. Findings: There is an acute comminuted impacted intertrochanteric fracture of right femur with overriding of the fracture elements and mild medial displacement of the lesser trochanter with moderate varus angulation of the fracture site. Impression: Acute comminuted mildly impacted intertrochanteric fracture of right femur with mild overriding of the fracture ends with moderate varus angulation of the fracture site and slight medial displacement of the lesser trochanter." There was a hand-written note at the bottom of the report which documented "faxed 3/8/22 at 0854 (8:54 AM)".

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R40's eMAR Note, dated 3/8/2022 at 1:01 PM written by V8, LPN day shift, documents a follow-up to the 3/8/2022 5:28 AM eMAR note, documents Tylenol 650 mg by mouth every 6 hours as needed for chronic pain resident still facial grimacing at this time.

R40's Nurse's Note, dated 3/8/2022 at 1:33 PM documents, "x-ray done results faxed to MD (physician's) office. Call from office physician's office to ask family preference of hospital for resident to go to for ortho and report to MD office. This nurse spoke with and updated wife POA of resident, wife stated she would be in facility to give response. Wife in facility at this time and chose local hospital for resident to transfer to, MD office notified staff to send resident. This nurse made call clarify that resident was to transfer from facility to local hospital ED (emergency department), ambulance called for transport of resident at 12:17 PM. Resident family in facility and updated. Resident left facility via ambulance at 13:05 PM, PRN (when needed) Tylenol given before resident left facility for pain, facial grimacing noted."

On 1/6/2023 at 10:50 AM, V8 day shift LPN stated she was the nurse who assessed R40 when he fell on 3/4/2022. V8 stated no staff told her R40 was in pain or had a change in condition in physical and occupational therapy on 3/7/2022. V8 stated she can't control what staff don't report to her what's going on with residents, she would have notified R40's physician on 3/7/2022 because she knew R40 fell a few days prior and would want to make sure he's ok. V8 sated when she got to work on 3/8/2022, V18, night shift Certified Nurse Assistant (CNA) reported to her that R40's right hip looked "different." V8 stated she didn't receive detailed nurse report from the

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S9999	Continued From page 11 night shift nurse, V19 because she was in a hurry to leave the facility. V8 stated she assessed R40 and noted his right hip was swollen and she notified the provider. V8 stated an x-ray was done and it was determined his right hip was fractured. V8 stated she didn't reassess R40 for pain after she assessed him that morning because there was a lot going on that day and she didn't get a chance to. V8 stated she administered PRN pain medication before R40 was discharged to the hospital. On 1/4/22 at 3:10 PM, V9, Medical Director, stated, "I would expect staff to know how to transfer residents and transfer them appropriately. I cannot say for certain, but more likely than not, this fall could have been prevented with two people assisting and gait belt." On 1/5/22 at 12:14 PM, V1, Administrator, stated, "I expect staff to know how residents transfer. We have a card for all nursing staff that shows transfer status and other important aspects of care for each resident. V14 who was assisting (R40) had one of those cards; she just did not look at it." On 1/5/22 at 1:00 PM, V15, Physical Therapist, stated, "All residents should be transferred with a gait belt. That is standard knowledge. If (R40) had been assisted by two people, his fall likely could have been prevented." On 1/6/2023 at 10:25 AM V9, Medical Director, stated she expected staff to communicate when a resident's experiences a change in condition. V9 stated when R40 didn't participate in physical and occupational therapy as he did on 3/4/2022 on 3/7/2022 that was a change in condition, and it should have been communicated to the nurse	S9999		

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and to the provider. V9 stated when staff was notified R40's right lower extremity had edema on 3/7/2022 she expected staff to assess the resident, document the assessment and then notify the provider, because he had a fall a few days prior. V9 stated when staff assessed R40 had facial grimacing on 3/8/2022 she expected staff to assess him, administer pain medication, if necessary, document the assessment in R40's medical record and to notify the provider.

The Facility's "Change in a Resident's Condition or Status" Policy last revised 1/2022 documents, "(Facility) shall promptly notify the resident, provider, and representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The nurse will notify the resident's provider when there has been a(an): accident or incident involving the resident; discovery of injuries of an unknown source; adverse reaction to medication; significant change in the resident's physical/emotional/mental condition; need to alter the resident's medical treatment significantly; refusal of treatment or medications two or more consecutive times; need to transfer the resident to a hospital/treatment center; discharge without proper medical authority; and/or specific instruction to notify the Physician of changes in the resident's condition. Except in medical emergencies, notifications will be made within twenty-four hours of a change occurring in the resident's medical/mental condition or status. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status."

The Facility's "Employee Counseling/Disciplinary Action Notice" dated 3/8/22 documents,

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	IL6007751	A. BUILDING: ______ B. WING ______	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED BUD REGIONAL CARE	350 WEST SOUTH 1ST STREET RED BUD, IL 62278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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"Violation: Failure to comply with Hospital Policy" Action Taken: Written Warning. Discussion: Transferred resident without gait belt and assist of one, resident is assist of two. Corrective Action Recommended: Transfer and gait belt training with therapy; 'Map of the World" training with DON (Director of Nursing). Employee's Remarks: Was not sure of resident being assist x 2, forgot my gait belt."

The Facility's "Falls Clinical Protocol" Policy last revised 8/2021 documents, "It is the policy of (Facility) to reduce the risk for falls. When falls do occur, (Facility) will identify causes and work to reduce risks of future falls. Falls Prevention - Potentially Interventions: Review ambulation status, review transfer status, orientation for staff and volunteers about fall prevention efforts and strategies, gait belt for transfers and ambulation, as appropriate. Strategies for Reducing the Risk of Falls: Assess gait and ambulation capabilities and identify abnormalities, identify and provide needed assistance for safe transfer and ambulation."

R160's Face sheet documents admission date of 10/1/2022. Face sheet documents diagnoses of diffuse large B cell lymphoma, intraabdominal lymph nodes, malignant neoplasm of kidney, benign prostatic hypertrophy.

R160's History and Physical dated 10/27/2022 documents "82-year-old male with B cell lymphoma. Has had complicated course-deep venous thrombosis, chemo, had congestive heart failure exacerbation-had been in and out of hospital recently at (local hospital) for shortness of breath-was at home for 10 days-progressively weaker, not able to care for self, fell at home, now here for 24-hour care."

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R160's Minimum Data Set (MDS) dated 11/3/2022 documents R160 has no cognitive deficits. MDS documents R160 required extensive two person assist with ambulation.

R160's Fall Risk Assessments, dated 10/1/2022, 10/26/2022, and 11/5/2022, documented R160 had score of 14, meaning he is at high risk for falls.

R160's Care Plan dated 11/14/2022 documents "(R160) is at risk for falls related to weakness related to chemotherapy and confusion at times. He has had two falls recently. He has alarms in place to alert staff to unassisted movement. He will use his call light at times to alert staff to needs." R160's Care Plan Interventions dated 11/14/22 are documented as follows: "Answer call light promptly and reorient to call light, if necessary; Ask resident every one to two hours if he/she needs to use the restroom and assist as needed; Assess and eliminate environmental hazards such as uneven surfaces, debris or water on floor; Assist resident to obtain and wear appropriate, non-skin foot ware; Keep bed in low position; Keep call light and water within reach; Maximize the resident's time out of bed as much as clinically possible to increase tolerance; and Use bed alarm when in bed, use chair alarm when in chair. "

R160's Progress Notes dated 11/30/2022 at 12:49 PM documents "At approximately 7:15 PM, CNA noted that (R160) was laying on the floor in prone position. Upon entering the room, this nurse noted that there was blood on the floor from beneath (R160)'s head. VS (Vital Signs) collected and assessment of (R160)'s condition collected. VS WNL (within normal limits), slow to

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respond to questions, pale complexion and aware of surroundings. No alarm was sounding. Chair alarm in place, not plugged in. Notified POA, no answer. Notified the on-call Nurse Practitioner at 7:17 AM and responded at 7:27 AM. Informed her of (R160)'s condition and received orders to send to hospital of family's choice. Notified EMS at 7:23 AM. Attempted again to reach POA, informed daughter of (R160) fall & condition, this nurse informed POA that (R160) was being sent to hospital. POA okay with sending resident. out. Paramedics arrived at 7:30 AM, then departed for hospital at 7:40 AM. hospital at 7:50 AM and gave report. At approximately 10:15 AM called hospital to check on (R160) status, was informed that CAT Scan (computerized axial tomography scan) was negative but did receive 8 staples to laceration and that (R160) would probably be returning back to facility within a couple hours. Checked in with hospital at 1:11 PM and was informed that (R160) was going to be admitted with Diagnosis of UTI."

R160's Incident Investigation dated 11/30/2022 documents "At 7:15 AM CNA (Certified Nursing Aide) noted that (R160) was laying on the floor in prone position. Upon entering the room, this nurse noted that there was blood on the floor from beneath (R160)'s head. Vital signs collected and assessment of (R160) collected. Vital signs within normal limits, slow to respond to questions, pale complexion and aware of surroundings. No alarm was sounding. Chair alarm in place, not plugged in. Notified Power of Attorney (POA), no answer. Notified the on-call physician at 7:17 AM. Physician returned call at 7:27 AM. Informed her of (R160)'s condition and received order to send to hospital of family's choice. Notified EMS (Emergency Medical Service) at 7:23 AM Attempted again to reach POA, informed

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S9999	Continued From page 16 daughter of (R160)'s fall and condition, this nurse informed POA that (R160) was being sent to local hospital. EMS arrived 7:30 AM and departed. At 10:15 AM called hospital to check (R160) status. Informed R160's CAT scan was negative but did receive 8 staples to laceration and that (R160) will be returning to facility in a couple hours. Checked in with hospital and was informed (R160) was to be admitted with diagnosis of urinary tract infection." On 1/4//2023 at 3:39 PM V9, Physician, stated "(R160) had multiple conditions going on. He had deep vein thrombosis, leukemia, and was taking chemo. He had multiple issues going on. He was weak, confused, forgetful and just didn't understand not to get up. The staff had him close to the nurse's station, mats were by his bed and recliner." When asked about R160's chair alarm being unplugged, V9 responded "I would've expected his chair to be plugged in." On 1/6/2023 at 9:25 AM V1, Administrator stated "The fall where (R160's) chair alarm was not plugged in, was because the CNA doing his AM care did not plug it back in. She was then terminated." (A)	S9999		