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	IL6004493	A. BUILDING: _____ B. WING _____	09/11/2023

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GREENVILLE NURSING & REHAB	400 EAST HILLVIEW AVENUE GREENVILLE, IL 62246

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S 000	Initial Comments Annual Licensure Certification	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)5) 300.1210c) 300.1210d)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. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	**Attachment A** **Statement of Licensure Violations**	

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

Restorative measures shall include, at a minimum, the following procedures:

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

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

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

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

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

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S9999	Continued From page 2 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. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to assess and determine potential root cause of falls; failed to develop interventions based on this assessment and implement interventions to prevent falls for 4 of 4 residents (R25, R34, R41, R65) reviewed for supervision to prevent accidents in the sample of 26. This failure resulted in R65 having three falls, the last which occurred on 8/24/23 resulting in a hip fracture. Finding include: 1. On 09/06/23 at 01:20 PM, R65 was lying in bed on his back. R65's reacher was observed to be on the floor at the head of the bed leaning against the wall and he was unable to reach it. R65 was wearing black socks that did not have grippers on the bottom. R65's chair alarm was hanging on his wheelchair. R65's Face Sheet, print date 09/07/23, documents R65 has diagnoses of Essential (primary) hypertension, nontraumatic acute subdural hemorrhage, moderate, cognitive communication deficit, other symptoms, and signs involving the musculoskeletal system, unsteadiness on feet, and other abnormalities of gait and mobility.	S9999		

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S9999	Continued From page 3 R65's Minimum Data Set, MDS, print date 09/07/23, documents R65 is severely cognitively impaired and requires limited assistance, one-person physical assist with bed mobility, dressing, personal hygiene, extensive assistance, one-person physical assist with transfer, toilet use, Balance: moving from seated to standing position, Not steady, only able to stabilize with staff assistance, Balance: surface-to-surface transfer, Not steady, only able to stabilize with staff assistance. R65's Fall Risk assessment, dated 07/06/23 at 5:30 PM, documents R65's total score is a 17. It also documents, "Total Score of 10 or above represents HIGH RISK. If High Risk, a prevention protocol should be initiated immediately and documented on the care plan." R65's Care Plan, print date 09/07/23, has no documentation R65 is at risk for falls and no interventions in place. R65 has documented falls on 7/6, 7/30 and 8/24/23. R65's Progress Notes, dated 07/06/23 at 6:56 PM, documents, "Certified Nursing Assistant (CNA) informed this writer resident was in floor in bathroom. This writer found res (resident) lying on left side on bathroom floor and was inc. (incontinent) large amount bm (bowel movement). Res. able to move all extremities and denies any c/o (complaints of) pain or discomfort. Full body assessment complete and noted small abrasion to left eyebrow and small abrasion to left elbow. Res said he was trying to get on toilet. Resident transferred to wheelchair (W/C) per 2 assist and given shower in shower room. Resident sitting in W/C (wheelchair) after next to nurse's station to monitor closely and sensor	S9999		

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alarm place in W/C. Resident educated on use of call light and to push call light for assist when needs to get up and resident stated "okay". Blood Pressure (B/P)-146/88, Pulse (P)-80, resps-20, Temperature (temp.) 98.5, Oxygen Saturation (SPO2) 96% on room air. V25, Physician on call exchange number left message and V25 returned call at11:02 pm and this writer notified V25 of fall and no new orders (NNO). On call supervisor notified of fall."

R65's Incident Investigation, dated 07/06/23 at 6:56 PM, documents, "Resident was noted to be laying on his left side in the floor in an episode of incontinence. He states, 'I was trying to get on the toilet.' Resident was new to our facility on this day and was experiencing confusion when he first arrived. He was assessed for injuries and noted to have a small abrasion to left eyebrow and small abrasion to the left elbow. At the time of incident, the call light was within easy reach and eyesight yet not activated. He was wearing shoes and the floor was free from spills/clutter. IDT (Interdisciplinary Teams) feels the resident would benefit from moving to a room in a higher traffic area. Care Physician (PCP)/Power of Attorney (POA) were made aware of interventions and agree."

R65's had no care plan related to falls after he fell on 7/6/23.

R65's Progress Notes, dated 07/30/23 at 07:30 PM, documents, "CNA notified this writer res was on floor crawling on his hands and knees. Sensor alarm was sounding. When this writer entered room res was in floor in crawling position on his hands and knees at end of bed. Res. able to move all extremities and denies any c/o pain or discomfort. Full body assessment complete, no

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injuries noted. Resident assisted back to bed per 2 assists. Res unable to answer what he was doing when this writer asked him". The Note documented R65 had no injuries.

R65's Incident Investigation, dated 07/30/23 at 7:30 PM, documents, "Review of incident documented on 07/30/23. During rounds, resident alarm sounding. Upon entering room, resident noted to be crawling on his hands and knees on the floor. The resident is unable to stated wheat happened. At the time of incident, the call light was within easy reach and eyesight yet not activated. He made no verbalizations to staff that he needed assistance. He was noted to not have socks or shoes on at that time. There were no spills / clutter in travel path. The IDT has reviewed and has recommended non-skid socks on while resident is not wearing shoes. PCP/POA updated and approve."

R65's Fall Risk Assessment, dated 07/30/23, documents R65's total score is a 16 (High Risk).

R65 had no Care Plan related to falls after the incident on 7/30/23.

R65's Resident Incident Report, dated 08/24/23 at 10:08 PM, documents, "Resident was on floor between the bed and bathroom door lying on his left side. Immediate Actions taken: Full body assessment with ROM (Range of Motion) completed."

R65's Fall Risk Assessment, dated 08/24/23, documents R65's total score is an 18 (High Risk).

There is no documentation that the facility implemented a care plan or care plan interventions after this fall.

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R65's Incident Investigation, dated 08/24/23 at 10:08 PM, documents, Narrative of investigation: "(R65), DOB (Date of Birth): 7/30/1945, BIMS (Brief Interview of Mental Status score)- 3, Parkinson's Disease, generalized anxiety disorder, nontraumatic acute subdural hemorrhage. On 08/25/23 at approximately 10:50 AM resident self-reported a fall to the therapy department during treatment. Therapy staff indicated that (R65) was completing his exercises but did complain of pain in the left leg. Therapy staff observed (R65) showing signs of pain while using his left leg and immediately informed appropriate staff. When (R65) was asked questions about the fall, he could not recall when he fell, only that he fell from his wheelchair. Resident stated he got up on his own post fall and did not report this to his nurse. (R65's) pain was assessed and treated per physician orders. Resident's physician was contacted with new orders received to obtain left hip x-ray. At 1330 (1:30 PM), facility was notified by the X-ray service of an acute intertrochanteric hip fracture. Resident's physician and resident representative was notified of the fracture. New orders received to send resident to hospital for further evaluation and treatment. Resident remains in hospital."

R65's Incident Investigation, dated 08/24/23 notes, "(R65) was interviewed upon return from hospital, and he reports that while in his room, he had a pamphlet from the local University, and while reading it, he dropped it, and it ended up on the floor. (R65) reports leaning forward to pick up the pamphlet and he fell forward onto his left side. (R65) is 1-person physical assist with transfers, and toileting and is independent with bed mobility. (R65) will have anti-rollbacks applied to his wheelchair and will be provided a reacher/grabber

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to assist him when trying to reach for things that are out of reach. Attending Physician and POA have been updated on the interventions put into place and agree."

R65's Progress Notes, dated 08/25/2023 at 02:32 PM, documents, Results of X-ray received at approximately (approx.) 1:17pm confirmed left (Lt) hip fracture (Fx). Transported to local hospital by ambulance at approx. (approximately) 1:50pm."

R65's X-Ray Report, dated 08/25/23, documents, "There are moderate arthritic changes of the hip with circumferential collar osteophytes and joint space narrowing. Acute fracture of the intertrochanteric hip. Boney mineralization is within normal limits for age. No evidence of osteomyelitis. Remainder of the pelvis is grossly intact. Impressions: Acute intertrochanteric hip fracture".

R65's Progress Notes, dated 08/25/2023 at 03:45 PM, documents notified V25, Physician of x-ray results. Orders received to send to Emergency Room (ER). POA aware and resident transported by ambulance to local hospital.

On 09/11/23 at 12:39 PM, V2, Director of Nursing (DON) stated if someone came in and was assessed and found to be a high fall risk, she would expect it to be care planned and that the staff need to be going with the care plan.

The facility's "Falls and Fall Risk, Managing" policy, dated 3/2018, documents, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize

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S9999	Continued From page 8 complications from falling. Resident-Centered approaches to managing falls and fall risk: 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls." -- 2. R25 was admitted to the facility on 5/16/22. The facility's fall log, documents R25 had a fall on 9/3/23 resulting in a head injury and was transferred to the local hospital. R25 received staples in his scalp. R25's Fall Risk Assessment, dated 5/16/23, documents R25 is a High Fall Risk with a score of 16. "Total score of 10 or above represents High Risk. If High Risk, a prevention protocol should be initiated immediately and documented on the care plan." R25's Care Plan, dated 5/16/22, documents R25 is at risk for falls. Interventions: (5/16/22) Prefers wearing tennis shoes, uses a wheelchair for long distance mobility, remind to ask staff for assistance with ambulation, needs a night light on to help see at night, monitor for changes in condition that may warrant increased supervision/assistance and notify the physician. (10/4/22) intervention to place (non-slip pad) Dysem in wheelchair and encourage resident to sit in recliner between meals, signage to bathroom door to ask for help. (2/4/23) Dysem in recliner. (4/18/23) Anti-skid socks to be worn while in bed. (9/4/23) Personal chair alarm until anti-rollbacks arrive. (9/6/23) Resident not to be left alone in room in his wheelchair. R25's Minimum Data Set (MDS), dated 7/21/23,	S9999		

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S9999	Continued From page 9 documents R25 has a moderate cognitive impairment and requires extensive assistance from one to two staff members for all ADLs. R25 is occasionally incontinent of urine and always continent of bowel. R25's Progress Note, dated 9/3/23 at 2:11 PM, documents, "Per resident - Attempting to self-transfer from wheelchair to recliner when he had fallen and hit his head resulting in a 2-3 inch laceration to left temporal forehead. Resident had used call light and stated that he became impatient while waiting for help to transfer. MD (Medical Doctor) and POA (Power of Attorney) notified. Resident sent to (Local Hospital) by ambulance." R25's Progress Note, dated 9/3/23 at 2:12 PM, documents, "(Local Hospital) called to update on resident. Resident is to return to facility with three staples to head laceration. To be removed in ten days. CT (Cat) scan was clear according to ER staff." R25's Progress Note, dated 9/3/23 at 3:11 PM, documents, "Resident returned to facility via stretcher/ambulance from (Local Hospital) ER (Emergency Room) where DR. (doctor) ordered CT scan which was negative. Alert x 3 (times three) with no complaints of pain or SOB (shortness of breath). Three Staples in left temporal area head measure 3.5 x 0.1. Cleansed with normal saline and open to air, v/s (vital signs) stable on room air (RA): 127/73, 97.3, 56, 93%, call light in reach and education r/t (related to) letting help assist him with further transfers, head elevated. Neuro checks completed and intact, wife at bedside and very appreciative for his treatment."	S9999		

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R25's Progress Note, dated 9/4/23 at 2:57 PM, documents, "CNAs voiced concern that resident again did not eat or drink anything at lunch and was zoning out a lot. Nurse evaluated resident and Neuros are WNL (within normal limit). VS are WNL, 95.3, 131/75, 55p, 16R, 97% RA. Resident has had a change in LOC (level of consciousness), increased lethargy, increased sleeping, increase in sporadic coughing, decreased lung sounds in the bases, increased weakness. D/t (due to) resident having a fall and open head injury yesterday, nurse would like to send resident to ER again. Nurse did request CT results from yesterday at SBL Vandalia Hospital, which were normal. Res called wife and spoke with wife. Wife agreed to allow res to be sent to ER again, this time we agreed upon (a different Local Hospital) rather than (previous hospital). EMS (Emergency Medical Service) has been paged. Administration is aware. Faxed MD with FYI (for your information)."

R25's Progress Note, dated 9/4/23 at 7:14 PM, documents, "(Local Hospital) called to give report on resident before they send him back. Per (ER Nurse) they want a UA (urinalysis) but resident would not let them straight cath him nor would he give them a urine sample. They want us to get a UA when he gets back here. Resident wife is at the bedside. The ER MD thinks resident has post-concussion syndrome. When MD called earlier in the day and this nurse spoke with him, he said that post-concussion syndrome can last from days to months and can come and go. (ER Nurse) said she would send copies of all resident results with him and doctor's notes and recommendations. Resident will be transported back to facility via rural med EMS."

R25's Fall Investigation, dated 9/3/23,

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documents, "The facility completed a comprehensive investigation to include resident/staff interviews and medical record review. The facility has determined (R25) transferred himself from his wheelchair to recliner. The wheelchair brakes were not locked at the time of the fall. The IDT (Interdisciplinary Team) met to discuss root cause of fall. The IDT determine (R25) would benefit from anti-rollbacks being placed on his wheelchair. The facility will order anti-rollbacks to be placed on (R25's) chair. Until their arrival, the facility will utilize a personal alarm. (R25) is currently being treated with occupational therapy services. Facility staff will request PT screen/evaluation as indicated to work on safe transfer techniques."

R25's Fall Risk Assessment, dated 9/6/23, documents R25 is a High Fall Risk. "Total score of 10 or above represents High Risk. If High Risk, a prevention protocol should be initiated immediately and documented on the care plan."

On 9/5/23 at 10:15 AM, R25 was sitting in his recliner chair, call light on chair, staples noted to left scalp. R25 stated he fell while trying to go to the restroom and hit his head. Tall back wheelchair has a (non-slip pad) and an alarm on the seat. R25 stated that he uses call light but sometimes it takes a while. There are signs on the restroom door; "STOP ask for help!" and "Use Gait Belt During Transfers".

On 9/6/23 at 2:25 PM, R25 was lying in his recliner, pad alarm under him in his recliner and pad alarm and (non-slip pad) is sitting in the seat of his wheelchair. Anti-tip bars seen on the back of his wheelchair. R25 had non-skid socks on.

On 9/7/23 at 11:04 AM, R25 was seen sitting in

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S9999	Continued From page 12 his wheelchair in his room by himself, pad alarm underneath him, however, the switch is turned to the off position and is not flashing. Per R25's Care Plan, (9/6/23) R25 is not to be left alone in his room while sitting in his wheelchair. 3. R41 was admitted to the facility on 5/4/23. The facility's fall log, documents R41 has had falls on 6/23/23, 7/7/23, and 7/13/23. R41's Care Plan, dated 5/4/23, documents R41 is at risk for falls. Interventions: (5/4/23) Prefers wearing tennis shoes, uses a wheelchair for long distance mobility, remind to ask staff for assistance with ambulation, needs a night light on to help see at night, monitor for changes in condition that may warrant increased supervision/assistance and notify the physician, assist with one staff member for all ambulation. R41 has a history of falls. Interventions: (5/4/23) Remind to ask staff for assistance with ambulation, prefers wearing tennis shoes, needs a night light on to help see at night, monitor for changes in condition that may warrant increased supervision/assistance and notify the physician, assist with one staff member for all ambulation, (5/9/23) Non-skid socks applied to resident, resident to be sat at table close to the service window. (6/26/23) Anti-rollbacks added to wheelchair, (7/7/23) Offer toileting before and after meals, (7/13/23) Offer resident to go to therapy with spouse when spouse receives therapy. R41's MDS, dated 8/11/23, documents R41 has a moderate cognitive impairment and requires extensive assistance from one staff member for ADLs.	S9999		

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	IL6004493	A. BUILDING: _____ B. WING _____	09/11/2023

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S9999	Continued From page 13	S9999		

R41's Admission Fall Risk Assessment, dated 5/4/23, documents R41 was a High Fall Risk with a score of 11. "Total score of 10 or above represents High Risk. If High Risk, a prevention protocol should be initiated immediately and documented on the care plan."

R41's Progress Note, dated 6/23/23 at 11:19 PM, documents, "Late entry: 06/23/23 at 9:00 pm. CNA asked this writer to check resident per was on floor in her room. This writer upon entering room resident was lying on right side next to end of bed and closet and wheelchair was behind her which she had been in wheelchair. Husband stated, 'She was trying to get up'. Resident able to move all extremities and denies any c/o (complaint of) pain or discomfort. Resident denies hitting her head. Full body assessment complete and no injuries noted. Neuro checks initiated. Resident said she was trying to get ready for bed. This writer educated resident to push call light for assistance and not safe to get up by self and resident stated, 'Okay'. Resident to bed per 2 assists. B/P-112/70, P-76, resps-18, temp. 97.6, spo2 97% on room air. Sensor alarm on bed and call light within easy reach. Dr. notified of fall at 11:10 pm and he said to call back if resident c/o any injuries."

R41's Fall Investigation, dated 6/23/23, documents, "Review of incident documented on 6/23/23. Resident was noted to be laying at the end of the bed on her right side with wheelchair behind her. She was assessed for injuries, and none noted. At the time of incident, the call light was within easy reach and eyesight yet not activated. She was wearing nonskid socks and the floor was free from spills/clutter. IDT feels the resident would benefit from anti-rollbacks on the wheelchair. PCP (Primary Care Physician)/POA

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S9999	Continued From page 14 were made aware of interventions and agree." R41's Fall Risk Assessment, dated 6/23/23, documents R41 was a High Fall Risk with a score of 21. "Total score of 10 or above represents High Risk. If High Risk, a prevention protocol should be initiated immediately and documented on the care plan." R41's Progress Note, dated 7/7/23 at 6:42 AM, documents, "06:25 AM: CNA informed this writer resident was on floor in bathroom. This writer went in room and resident was lying on right side next to toilet. Resident able to move all extremities and denies any c/o pain or discomfort. Full body assessment complete, no injuries noted. Resident said she was trying to sit on toilet. Resident assisted on toilet per 2 assists. Resident voided and in wheelchair per 2 assists after. Sensor alarm in wheelchair. Neuro checks initiated. Resident reoriented to push call light when need to get up and resident stated "Okay". B/P-148/74, P-88, resps. 20, temp. 98.4, SPO2 96% on room air. Dr. on call exchange number called and no response. On call supervisor notified of resident's fall." R41's Fall investigation, dated 7/7/23, documents, "Review of incident documented on 7/7/23. Resident was noted to be lying on her right side next to the toilet. She states that she was trying to sit on the toilet. She was assessed for injuries, and none noted. At the time of incident, the call light was within easy reach and eyesight yet not activated. She was wearing non-skid socks and the floor was free from spills/clutter. Upon further investigation resident attempted to transfer herself to the bathroom without the use of the call light. IDT feels the resident would benefit from assistance toileting before and after meals due to	S9999		

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S9999	Continued From page 15 resident's mental confusion. PCP/POA were made aware of interventions and agree." R4's Fall Risk Assessment, dated 7/7/23, documents R41 was a High Fall Risk with a score of 21. "Total score of 10 or above represents High Risk. If High Risk, a prevention protocol should be initiated immediately and documented on the care plan." R41's Progress Note, dated 7/13/23 at 3:42 PM, documents, "Notified per DON (Director of Nursing) at 1:50 pm that resident was in room in floor with alarm going off. Upon entering room, nurse and DON assisting resident to wheelchair, they stated when they entered room resident was on knees and crawling to wheelchair from stationary chair looking for husband, some redness to bilateral knees ROM (Range of Motion) good, vitals 97.7-78-20-122/69-98%. No c/o pain. Dr. office notified at 2:47 pm. Message left for daughter to call back at 2:45 pm. called daughter's husband and was updated on fall he stated he would let her know." R41's Fall investigation, dated 7/13/23, documents, "Review of incident documented on 7/13/23. Resident was noted to be on her knees in front of her chair in the room. She states that she was looking for her husband because "He had been gone for a long time." Resident's husband was in therapy at the time. She was assessed for injuries, and none noted. At the time of incident, the call light was within easy reach and eyesight yet not activated. She was wearing tennis shoes and the floor was free from spills/clutter. IDT feels the resident would benefit from staying with husband when he goes to therapy. PCP/POA were made aware of interventions and agree."	S9999		

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S9999	Continued From page 16 R4's Fall Risk Assessment, dated 7/13/23, documents R41 was a High Fall Risk with a score of 13. "Total score of 10 or above represents High Risk. If High Risk, a prevention protocol should be initiated immediately and documented on the care plan." On 9/5/23 at 11:02 AM, R41 was sitting in her recliner, a walker and wheelchair in the room and chair pad alarm under her. Husband (R44) was in room with R41. R44 stated R41 has fallen a few times here at the facility. R41's wheelchair was without anti-roll bars on back. V9, CNA, entered to assist R41 from her recliner to her wheelchair. V9 did not use a gait belt and grabbed R41 under her left arm and assisted her to stand and pivot to her wheelchair. Upon standing the pad alarm underneath R41 did not sound, indicating that it was not functional at the time. On 9/5/23 at 12:30 PM, R41 and her husband (R44) were sitting in dining room on opposite side of the dining room from the serving line. Per care plan, R41 should be sitting at a table close to the service window. On 9/6/23 at 9:42 AM, R41 was sitting in her wheelchair with husband (R44) in the room with her, call light on her bed and within reach, shoes on. Wheelchair without anti-roll bars on back side. On 9/7/23 at 11:07 AM, R41 sitting asleep in her wheelchair in the dining room, tennis shoes on, chair pad alarm underneath her and is in the on position and flashing. There are no anti-roll bars seen on her wheelchair. 4. R34 was admitted to the facility on 6/23/23.	S9999		

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The facility's fall log, documents R34 has had falls on 8/15/23 and 8/23/23.

R34's Admission Fall Risk Assessment, dated 6/23/23, documents R34 was a High Fall Risk with a score of 14. "Total score of 10 or above represents High Risk. If High Risk, a prevention protocol should be initiated immediately and documented on the care plan." Even though R34 was a High Fall Risk upon admission, R34 had no fall interventions in place in his Care Plan until after his fall on 8/15/23.

R34's Care Plan, dated 8/15/23, documents, "Safety: Poor safety awareness fall 8/15/23. Interventions: (8/17/23) Refer to Physical Therapy for evaluation, remind to ask staff for assistance with ambulation, needs a night light on to help see at night, monitor for changes in condition that may warrant increased supervision/assistance and notify the physician, keep walker within reach at all times, assist with one staff member for all ambulation, assist with stand-by-assist for all ambulation, therapy to evaluate for use of a reacher, ask for assistance when dropping things on floor, (8/23/23) BP daily x 1 week. Then fax to MD, Orthostatic BP's x 3 days."

R34's MDS, dated 6/30/23, documents R34 has a moderate cognitive impairment and requires extensive assistance from one staff member for transfers and toileting. R34 was occasionally incontinent of urine and always continent of bowel.

R34's Progress Note, dated 9/15/23 at 9:54 PM, documents, "At 7:15 PM, resident Found by LPN (Licensed Practical Nurse) on floor and got writer. Writer walked up to resident in middle hallway by

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med room on floor laying on right side. Resident denies hitting head. Resident stated he came out to get a snack, and dropped bags of Wafers on floor bent down to pick them up lost his balance tried to grab snack, but it rolled, and he fell to the floor. Denies any pain/disc. assisted to sitting position. ROM's WNL. Vitals Signs 98.0 - 82 - 22 - 124/68 spo2 @ 100%. RA. Assisted resident to feet X 2 assist. SBA (stand by assistance) with w/w (wheeled walker) and assessed in Room. No redness or s/sx (signs/symptoms) of apparent injures. Neuros initiated. At 7:25 PM, called POA and aware on resident fall. At 7:28 PM, Called on call for Dr. office and NP answered aware of fall with no injuries. NNO (no new orders) update MD with any changes."

R34's Progress Note, dated 8/17/23 at 4:16 PM, documents, "Resident has complained of right hip pain and stated it started last night and thinks it is from his fall. Dr. office notified and faxed over new order for X-Ray to right hip due to the acute pain in right hip. Resident aware of order and verbalizes understanding."

R34's Progress Note, dated 8/18/23 at 12:41 AM, documents, "(X-ray provider) x-ray results received and faxed to physician. No evidence of fracture or dislocation noted. Osteopenia noted."

R34's Fall Investigation, dated 8/15/23, documents, "IDT met to discuss root cause of fall. IDT determined resident dropped his snack and bent over pick it up. Resident lost balance and fell to floor. Resident immediately educated to ask for assistance when picking items up off floor. Resident currently receiving skilled therapy. IDT will ask therapy to evaluate/screen resident for reacher use."

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S9999	Continued From page 19 R34's Fall Risk Assessment, dated 8/15/23, documents R34 is a High Fall Risk with a score of 15. "Total score of 10 or above represents High Risk. If High Risk, a prevention protocol should be initiated immediately and documented on the care plan." R34's Progress Note, dated 8/23/23 at 8:04 PM, documents, "Late entry - At approx. 6:15 PM, resident had fallen in the bathroom again and had his emergency light on. CNA entered room and fetched nurse. Resident was noted to be laying on his right side in the bathroom. Feet in front of toilet, head, and body towards shower stall and in shower stall. Resident denies hitting his head. No lumps or discoloration noted to body at all. No apparent injuries noted. ROM WNL. Neuros WNL. Initial VS at 1815; 98.7, 86/37, 74p, 97%RA, 18R. Admin aware, POA aware, MD aware. Per MD- Monitor per facility protocol for neuros and check BP Q12 H x 1 week and send log." R34's Fall Investigation, dated 8/23/23, documents, "IDT met to discuss root cause of fall. Review reveals residents BP at time of fall was 86/37. IDT feels low BP may have contributed to fall. Nursing staff to complete orthostatic BP's X 3 days. Facility leadership requested medication review by Pharm D for any medications that would contribute to low BP. Orthostatic BP obtained no huge variances noted. Pharm D medication review completed. Review to be discussed with NP or MD on next visit. Staff continues to monitor BP X 1 week; results will be faxed to MD." R34's Fall Risk Assessment, dated 8/23/23, documents R34 is a High Fall Risk with a score of 11. "Total score of 10 or above represents High	S9999		

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S9999	Continued From page 20 Risk. If High Risk, a prevention protocol should be initiated immediately and documented on the care plan." On 9/11/23 at 11:29 AM, V2, DON, stated, "I would expect the staff to follow a resident's fall precautions as outlined in their care plans and per the facility's policy." (A)	S9999		