STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008072	A. BUILDING: _____ B. WING _____	10/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINGS MANOR RHC	502 NORTH MAIN BRIGHTON, IL 62012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: One of Two: 300.610a) 300.1210a) 300.1210b)4)5) 300.1210c) 300.1210d)4)A)C)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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'	S9999		

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S9999	Continued From page 2 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: 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. C) Each resident shall have clean, suitable clothing in order to be comfortable, sanitary, free of odors, and decent in appearance. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to reposition and toilet resident timely for 3 of 3 (R14, R17, R35) residents reviewed for pressure ulcer prevention. This failure resulted in R14 and R17 experiencing daily pain in buttocks, R14 experiencing pain in left hip, and R35 obtaining a pressure ulcer to the right buttock.	S9999		

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S9999	Continued From page 3 1. R14's Care Plan, dated 5/16/2023, documents High Risk for Pressure ulcer per Braden Assessment. High Risk Factors include reduced mobility and incontinence. Strengths include can make needs known if uncomfortable. Lotion skin with cares and prn (as needed), avoid friction over boney prominences. Maintain clean, dry, wrinkle free linens. R14's MDS, dated 9/25/23, documents that R14 is totally dependent on 2 staff for bed mobility, locomotion on and off the unit toileting and transfers. R14's Comprehensive Nursing Assessment, dated 9/26/23, documents that R14 is able to make needs known and that R14 is unable to scoot buttocks while sitting. R14's Braden Scale, dated 9/26/2023, documents that R14 is on a turning schedule. R14's Turn Schedule posted in room next to bed documents 1AM/PM Door, 3 AM/PM Window, 5 AM/PM Back, 7 AM/PM Door, 9 AM/PM Window, 11 AM/PM Back. On 10/11/2023 from 8:10 AM to 9:08 AM, R14 was observed sitting in wheelchair in the dining room without the benefit of repositioning. At 9:08 AM, R14 was transported from the dining room and sat in front of the nurse's station. R14 was not toileted or repositioned at this time. From 9:08 AM to 10:00 AM, R14 was observed sitting at the nurse's station without the benefit of repositioning. At 10:00 AM, R14 was transported to the dining room for activity. From 10:00 AM to 10:50 AM with 15-minute interval checks, R14 was seen sitting in the dining room in her	S9999		

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S9999	Continued From page 4 wheelchair without the benefit of repositioning. At 10:51 AM, R14 was transported to the nurse's station. R14 was not toileted or repositioned at this time. From 10:51 AM to 12:03 PM, R14 sat at the nurse's station in the wheelchair without the benefit of repositioning. At 12:03 PM, R14 was transported to the dining room. From 12:03 PM to 1:11 PM, with 15-minute intervals, R14 sat in the dining room in her wheelchair eating her noon meal without the benefit of repositioning. At 1:11 PM, R14 was transported to the nurse's station. R14 was not toileted or repositioned at this time. From 1:11 PM to 1:50 PM, R14 sat at the nurse's station in her wheelchair, without the benefit of repositioning. At 1:50 PM, R14 was taken to her room. From 2:00 to 2:10 PM, R14's treatment was performed to her chest, no toileting or repositioning occurred at this time. At 2:10 PM, R14 was assisted outside to activity. From 2:10 PM to 3:00 PM, R14 was sitting outside in wheelchair, without benefit of repositioning. At 3:00 PM, R14 was transported into the dining room. From 3:00 PM to 3:25 PM, R14 was in the dining room sitting in wheelchair without the benefit of repositioning. At 3:25 PM, V14 (Licensed Practical Nurse/LPN), and V15 (Certified Nursing Assistant/CNA) assisted R14 into the bed using a full body lift. At 3:40 PM, V15 and V16 (CNA's) provided incontinent care. V15 and V16 removed R14's incontinent brief and revealed multiple indentations to R14's right and left buttocks from the urine saturated incontinent brief. On 10/11/2023 at 3:30 PM, R14 stated that she does not like to sit up for long periods of time. R14 stated that this hurts her. R14 stated that she is hurting at this time. R14 stated that she hurts all over but her bottom and her left hip hurts bad. R14 stated that this happens when she sits	S9999		

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S9999	Continued From page 5 in her chair all day. On 10/11/2023 from 3:40 to 4:00 PM, R14 yelled out in pain during incontinent care. R14 stated that her hip hurt. 2. R35's Admission Record documents admission to the facility on 3/6/23. The resident diagnoses included late onset Alzheimer's disease, hyperlipidemia, and psychophysiological insomnia. R35's Minimum Data Set (MDS), dated 9/27/23, documents that R35 is severely cognitively impaired. R35's Care Plan, dated 9/28/23, documents that R35 is at risk for pressure ulcers per Braden risk assessment score of 20. Risk factors included incontinence. The care plan goal included R35 will have no new open areas caused by pressure or friction for the next 90 days with goal date of 12/27/23. Interventions included: daily skin checks to be done first month, and as needed with any new open area, assess skin and if open notify physician, apply incontinent barrier cream to peri area with every after incontinent episode and as needed, toilet/change brief when wet, upon rising, at bedtime and after meals. R35's Braden Scale for predicting pressure ulcer risk, dated 9/28/2023, documents that R35 is very moist, has a potential problem for friction and shear. R35's Pressure Sore Record, dated 9/28/23, documents Stage II pressure ulcer measuring 2cm (centimeters) x 3cm to R35's Rt (right) buttock. It continues 10/5/23 right buttock, Stage I, unmeasurable, color pink, open area healed.	S9999		

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S9999	Continued From page 6 Risk Factors/Cause incontinence and Alzheimer's Disease. R35's Physician Orders (POS), dated 9/28/23, document that R35 had an order to cleanse area to buttocks, pat dry, apply comfort foam and change every 3 days. This order was discontinued on 10/5/23. On 10/11/23 from 7:40 AM to 11:45 AM, R35 was sitting in her wheelchair at the nurse's station without the benefit of being repositioned or offered to toilet. At 11:45 AM, R35's family arrived at the facility and transferred R35 into the recliner in R35's room. From 11:48 to 12:15 PM, R35 sat in the recliner without the benefit of toileting or repositioning. At 12:16 PM, R35's family transferred R35 into her wheelchair and wheeled R35 into the dining room. From 12:16 PM to 1:50 PM, R35 sat in the dining room without the benefit of repositioning or toileting. At 1:51 PM, R35 was transported to the nurse's station. From 1:51 PM to 2:00 PM, R35 sat at the nurse's station. At 2:00 PM, V12 and V13 (both CNAs) assisted R35 with incontinent care. R35 was incontinent of urine. V12 and V13 assisted R35 into a standing position revealing R35's urine saturated pants. During incontinent care, surveyor observed a quarter sized circular open area to the right buttock with 3 dark red linear areas measuring approximately 1-centimeter slits inside the open area. No treatment in place. On 10/12/23 at 3:00 PM, review of R35's Medical Record, POS, and Treatment Record does not document the presence of, orders, or treatment for the area observed on 10/11/23 described above. On 10/10/2023 at 9:15 AM, V19 (Licensed	S9999		

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S9999	Continued From page 7 Practical Nurse/LPN) stated that R35 had a pressure ulcer to her buttocks but it had healed. On 10/11/2023 at 2:08 PM, V12 (CNA) stated that R35 had an open area that was being treated. On 10/16/2023 at 8:13 AM V2 (Director of Nursing/DON) stated that she was not aware of R35's area. V2 stated that she was told by the wound nurse that the area was healed. V2 stated that the Braden Scale is used to determine the risk for pressure ulcers. 3. R17's Admission Record, undated, documents R17 was admitted to the facility on 4/12/16. R17's Medical Record documents diagnoses to include Multiple Sclerosis, Thyroid Disorder, HTN (hypertension), Neurogenic bladder, Depression, Quadriparesis, COVID-19, UTI (Urinary Tract Infection), and Sepsis. R17's Care Plan, dated 5/26/23, documents R17 is unable to assist/assist minimally with ADLs (Activities of Daily Living). Interventions: Unable to maintain balance on toilet - not a candidate to place on toilet. Place brief on when up-check every two hours and PRN (as needed), change as needed, pad on bed, change every two hours and PRN when repositioning, cleanse peri-area after each incontinent episode, barrier cream as needed upon cleansing. It continues R17 has alteration in elimination - incontinent bowel - can let staff know when she needs incontinent care. Interventions: Pad appropriately for dignity and comfort, change padding and give proper hygiene before/after meals, upon arising, upon request, before retiring for the evening, after napping, and PRN for incontinence, apply house stock barrier cream with every after-incontinence care. It	S9999		

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S9999	Continued From page 8 continues R17 is a High Risk for Pressure Ulcer. Interventions: Skin risk assessment quarterly, reposition per positioning schedule - reposition approximately every two hours, pressure relieving device in wheelchair foam, pressure relief mattress in bed foam, apply house stock (brand name cleanser and protectant) to peri-care after incontinent episode and as needed, toilet/change brief when wet and upon rising, at HS (bedtime) and after meals, lotion skin with cares and PRN, avoid friction over boney prominences. R17's MDS, dated 8/17/23, documents R17 is cognitively intact and requires total dependence of two staff members for bed mobility, transfers, dressing, personal hygiene, toilet use, and bathing. R17 has a urinary catheter in and is always incontinent of bowels. R17's Monthly Weight Grid, dated November 2022 through October 2023, documents R17's weight in September 2023 as 187 pounds and her Height as 63 inches which makes her Body Mass Index (BMI) 33.2. According to the Centers for Disease Control and Prevention (CDC) website CDC.gov, the Adult BMI Calculator, indicates R17's weight is in the Obesity Category. On 10/11/23 at 7:42 AM, R17 was seen coming from the shower room on the shower bed to her room by V8 (CNA). V6 (CNA) entered the room to assist V8. Both CNAs donned their gloves with no Hand Hygiene observed to be done prior. R17 already had a sling underneath her and appeared still wet from her shower. The sling was attached to the full body mechanical lift device, and R17 was lifted off the shower bed and pushed to her bed with V8 holding her legs. Water was seen dripping from R17 during transfer to R17's bed. R17 was disconnected from the lift device and	S9999		

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S9999	Continued From page 9	S9999		

rolled to her right side. R17 had a bowel movement that was found upon rolling her over. V6 (CNA) used wet wipes to clean R17's anal area to wipe the feces off and did not clean the buttocks or anything else. R17's entire buttock area (right and left side) appeared very red and excoriated with V8 stating R17's butt always looks like that. V6 then used the same soiled gloves he used to wipe R17's anal area and put a clean incontinence brief on R17, then rubbed lotion all over R17's back. R17 was rolled to her left side and V8 removed the wet linen. R17 was then rolled to her back and was dressed by both CNAs using the same soiled gloves. V8 then used the same soiled gloves to rub lotion on R17's chest. There was no barrier cream put on her buttocks. R17 was then put into her wheelchair for breakfast.

On 10/11/23 at 2:50 PM, R17 had been seen sitting in her wheelchair continuously since before breakfast, as stated above. R17 is now lying in bed, with the head of the bed elevated and a pillow under each arm. R17 has a normal size bed with R17's BMI of 33.2 and her body going from one side of the bed to the other. R17's rails are down to give her more room in the bed.

On 10/11/23 at 2:52 PM, R17 stated "They put me back to bed after lunch today, around 1:30 or so, which was later than usual. I usually get up to my wheelchair for breakfast and will be sitting in my wheelchair until after lunch, then I get back in bed. They will get me back into my wheelchair for dinner. No matter if I'm in my wheelchair or in my bed, I'm always on my butt. I asked for a larger bed because I think I can turn myself a little, or they could actually turn me on my side if I had a bigger bed, but they told me it was going to be $300/Month. They put pillows under my arms

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S9999	Continued From page 10 but don't actually turn me to get the weight off my butt. My butt has been red and sore for a long time. Sometimes it's better and sometimes it's worse. It does hurt every day, but I think I am just tolerant of it now. I know when I'm incontinent and will tell them, so I don't think it's because of that. I have a urinary catheter, so I am not sitting in urine anymore. I think it's because I'm on my butt all day long. If you could do something to help me, I would appreciate it." On 10/12/23 at 2:37 PM, V17 (LPN), stated "(R17) would definitely benefit from a larger bed." 10/16/23 at 12:32 PM, V2 (DON) stated "(R17) has not asked me for a larger bed, but I know we have (V9 Maintenance) looking to get a larger bed right now." The facility Pressure Sore Prevention policy dated 4/2006 documents: To provide adequate interventions for the prevention of pressure ulcers for residents who are identified as HIGH or MODERATE risk for skin breakdown as determined by the Braden Scale. Turn and reposition every two hours for high and moderate risk Turning and position may be more often than every two hours for high risk, if indicated. Incontinence Care for high and moderate risk may include lotions, barrier creams. Any resident scoring a High or Moderate risk for skin breakdown will be noted on the Treatment sheet and signed off by the nurse. In addition, a brief weekly narrative will be completed describing the resident's skin condition on the back of the treatment sheet. (B)	S9999		

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S9999	Continued From page 11 Two of Two 300.610a) 300.1210a) 300.1210b)4)5) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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	S9999		

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S9999	Continued From page 12 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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:	S9999		

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S9999	Continued From page 13 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 were not met as evidence by: Based observation, interview and record review, the facility failed to monitor and thoroughly assess root causes of falls to ensure progressive interventions that correlate to the cause are implemented for resident safety, for 4 of 5 residents (R9, R16, R35, R92) reviewed for falls and transfers. The facility also failed to check the straps to the full mechanical lift prior to moving a resident and failed to ensure the chair wheels were locked. These failures resulted in R35 having multiple falls with injury as well as pain in her right foot due to untreated fracture. Findings include: 1. R35's Care Plan was reviewed on 10/11/2023 and does not address R35's falls. R35's Fall Risk Assessment, dated 9/28/2023, documents that R35 is at High Risk for falls. R35's Nurses Notes, dated 4/24/2023 at 9:30 AM, documents that resident was observed sitting on floor next to chair in nurse's station and appeared to have been falling asleep and slid from chair. R35's Quality Care Reporting form dated 4/25/2023, documents that R35 fell asleep in	S9999		

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S9999	Continued From page 14 chair and slid out. Intervention was to only let her sit in chairs with arms. R35's Nurse's Notes, dated 7/31/23 at 10:00 AM, documents that R35 was found on floor, due to unknown if resident hit her head R35 was sent to the hospital. 3:45 PM resident returned from the hospital. No report called from the hospital. Daughter states that all scans, imaging, and bloodwork were fine. R35's Quality Care Reporting form dated 7/31/2023, documents that R35 was lying on floor flat on back. Areas of concern identified for further analysis: increased confusion. Intervention: continue to keep in staff eyesight. R35's Nurses Notes, dated 8/2/2023 at 9:30 AM, documents Resident daughter is concerned about how fatigued R35 is and believes that R35's right foot is hurting her. Right ankle is swollen, slightly reddened and warm to touch. Resident sent to ER. R35's Nurses Notes, dated 8/2/2023 at 4:30 PM document resident returned from hospital with family in w/c (wheelchair). Family reported Diagnosis of Cellulitis. R35's (Local) Hospital X-ray result dated 8/2/23 documents Right ankle and right foot 3 or more views. Reason for study: pain. Complains of right foot and ankle pain x (times) 2 days. Per daughter R35 was found on the floor 2 days ago. Impression: 1. Mild osteopenia with mild soft tissue swelling involving right foot with curvilinear osseous, fragment noted along the inferior margin of the calcaneus, which may represent an avulsion type fracture. Clinical correlation with point tenderness is recommended. 2. Cortical	S9999		

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S9999	Continued From page 15 irregularity and lucency involving medial malleolus, which raises concern for a minimally displaced avulsion type fracture. Clinical correlation with point tenderness recommended. R35's Nurses Notes, dated 8/20/23 at 6:15 AM, (R35) observed sitting on floor. No injury noted at this time. R35's Quality Care Reporting form dated 8/20/2023, documents that R35 was lying on floor flat on back. Areas of concern identified for further analysis: resident likes to sit down on the floor. Intervention: Blank. R35's Nurses Notes, dated 9/13/23 at 12:30 PM document that R35 was complaining of right foot pain. Seems to be limping. R35's Nurses Notes, dated 9/15/23 at 11:15 AM, R35's R (right) foot red and swollen, warm to touch, Resident sent to the hospital. R35's Nurses Notes, dated 9/16/23 at 5:30 PM document R35 returned to the facility Redness noted to the anterior aspect of the Right foot. Minimal edema to the right ankle. R35's Nurses Notes, dated 9/17/23 at 5:00 AM document resident not wanting to stand, dressing required to person. 10:15 AM Resident is having c/o (complaints of) pain in bilateral feet. Right foot reddened but not swollen. Is having difficulty ambulating. R35's Nurses Notes, dated 9/24/2023 at 10:35 AM document redness and swelling to BL (bilateral) feet. Facial grimacing noted upon touch to both feet. As needed pain medication was given. R35 was unable to bear weight to	S9999		

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S9999	Continued From page 16 lower extremities. Significant change in condition related to care provided with ADLs (Activities of Daily Living). R35's Nurses Notes, dated 10/1/23 at 8:00 PM document resident had a fall, did hit head. R35's Quality Care Reporting form dated 10/1/2023, documents that R35 was on the floor lying on side. Areas of concern identified for future analysis: Blank. Intervention: resident toileted and repositioned. R35's Nurses Notes, dated 10/9/23 at 9:35 PM document R35 noted sitting on the floor with legs extended to the front. R35's Quality Care Reporting form dated 10/9/2023, documents that R35 was sitting on floor with legs extended near door. Areas of concern identified for further analysis: blank. Intervention: client placed on 1 on 1 until anxiety dissipates. On 10/16/2023 at 8:13 AM V2 (Director of Nursing/DON) stated that she is aware that there are no fall interventions for R35. V2 stated that R35 should have interventions in place. V2 stated that R35 has dementia and has had problems with her foot. V2 stated that R35 has had pain and swelling in her right foot. V2 stated that she has done everything she could. V2 stated that she has treated R35 for cellulitis, and gout and neither was the problem. V2 stated that she is aware of reasons R35 is falling. V2 stated that R35 has a fracture to her foot and that they didn't treat it. V2 stated that this is the cause of her falls. V2 stated that because of R35's dementia she does not stay off her feet which causes her pain and R35 to fall. V2 stated that	S9999		

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S9999	Continued From page 17 she knows this, just can't do anything about it. On 10/16/23 at 10:55 AM, V11 (Licensed Practical Nurse/LPN) stated "I am fairly new, I will have to check the chart" when asked what fall reduction interventions are in place for R35. On 10/16/23 at 11:00 AM, V10 (Certified Nurse Assistant/CNA) stated "We try to put her in her chair, bring her to the nurse's station and keep her busy. She usually falls at night." 2. R16's Admission Record, undated, documents R16 was admitted to the facility on 4/13/17. R16's Medical Record documents R16's diagnoses to include Cerebral Vascular Accident (CVA), Diabetes Mellitus (DM), Hypertension (HTN), Depression, Osteoarthritis, Ataxia, Carotid Artery stenosis, Multi-infarct Dementia, Acute Kidney injury, Leukocytosis, Hyperlipidemia, and Chronic Obstructive Pulmonary Disease (COPD). R16's Care Plan, dated 7/11/23, documents Falls: Resident has risk factors that require monitoring and intervention to reduce potential for self-injury. Risk factors include Balance issues from old CVA. Interventions: Ensure adaptive devices - walker/wheelchair within reach and in good repair, encourage and assist placement of proper non-skid footwear, remind resident to lock w/c brakes, fall risk assessment quarterly and as needed with change in condition or fall status, keep environment well-lit and clutter free, keep call light within reach at all times and answer promptly and notify resident that help is coming. Fall on 6/22/23: Resident attempted to transfer himself from wheelchair to bed. The bed "moved on him" and he fell. Interventions: Remind resident with frequent verbal cues to use call light	S9999		

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for all transfers, keep call light within reach, staff to answer call light promptly if staff is nursing, explain that he/she will find CNA or Nurse to assist. Fall on 7/17/23: Resident woke up (morning) and was attempting to transfer self from bed to chair and fell. States "I slipped off the side of the bed." Interventions: Frequently remind resident to utilize call light, always encourage resident to have assist with all transfers d/t (due to) his history of feeling his knees buckle. Fall on 9/20/23: Resident assisted with transfer, while doing so, he said his knees gave out and was lowered to the floor. Interventions: Encourage resident to inform staff when being transferred of weakening he feels in his legs/knees, CNAs/Nurses to continue with correct transfer techniques, staff to provide continued encouragement reminders to use call light to request assist with all transfers.

R16's Minimum Data Set (MDS) dated 9/26/23, documents R16 has a moderate cognitive impairment and requires extensive assistance from two staff members for bed mobility, transfers, dressing, toilet use, and bathing. R16 is occasionally incontinent of both bowel and bladder.

The Facility's Fall Log, documents R16 had falls on 9/20/23, 8/9/23, 7/17/23, 6/2/23, 4/28/23, and 4/14/23.

On 10/10/23 at 8:50 AM, R16 was sitting in his wheelchair, wheeling around his room, stated he has fallen several times at the facility.

On 10/12/23 at 10:40 AM, R16 stated "My bed does not lock unless you lower it all the way to the floor. That is how I fell a couple times; I was trying to get out of bed to my wheelchair and the

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S9999	Continued From page 19 bed moved on me. I do not walk by myself, and I am supposed to call for help to get up." On 10/12/23 at 10:43 AM, R16's bed was easily movable with one hand. A brake on a wheel at the foot of the bed was not functioning. R16's Care Plan Interventions after each fall do not address R16's bed moving during transfer. On 10/12/23 at 2:25 PM, V15 (CNA) stated "The only way to know someone is a fall risk is a leaf placed on their name plate at the entrance to their room. I'm not sure what fall precautions any resident has. We usually have the resident's walker or wheelchair within reach for them." On 10/12/23 at 2:28 PM, V17 (LPN), stated "We have a Fall Policy at the nurse's desk that has a list of Fall Interventions that we can use." On 10/12/23 at 2:35 PM, V17 stated "Some of these beds have to be lowered to the ground for the bed legs to reach the floor, then it won't move. If the bed is raised, there should be a lock on the wheel to keep it from rolling. I see that (R16's) bed still moves when it's lifted." R16's Quality Care Reporting Form, dated 4/14/23 at 5:20 AM, documents R16 was found on his buttocks on the floor by his bed. R16 stated that his legs slid off the bed and he went with them while he was attempting to get out of bed for the day. The new intervention implemented was for a PT (Physical Therapy) Evaluation. R16's Quality Care Reporting Form, dated 4/28/23 at 8:00 PM, documents R16 was found on his bottom leaned back next to his bed. R16 stated that he was attempting to put himself to	S9999		

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bed and when he leaned onto the bed, it moved, causing him to slide down. The new intervention implemented was to educate resident on asking for assistance.

R16's Quality Care Reporting Form, dated 6/2/23 at 5:25 AM, documents R16 was found lying on his back on the floor. R16 stated he was transferring himself to his chair and the bed moved and he slid to the floor. The environmental safety issue documented was the bed was not locked. The new intervention implemented was for the resident to be reminded to use call light for assistance.

R16's Quality Care Reporting Form, dated 7/17/23 at 5:15 AM, documents R16 was found lying on the floor next to his bed, after trying to get out of bed and slipping off the side of his bed. There was no new intervention documented.

R16's Quality Care Reporting Form, dated 8/9/23 at 2:45 AM, documents R16 was found lying on his left side between his bed and the wall. R16 stated he was trying to get up and is requesting for his sleeping pill to be increased. The new interventions implemented was awaiting word from doctor about sleeping medication increase.

R16's Quality Care Reporting Form, dated 9/20/23 at 5:15 AM, documents R16 was found on the floor between the bed and the wall. R16 stated that his knee gave out and he started to go down. Environmental Safety issue documents that the bed was not locked. Areas of concern documents that the bed remains unlocked. The new intervention implemented was for the staff to ensure bed is locked when putting resident to bed.

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S9999	Continued From page 21 R16's Fall Risk Assessment, dated 6/29/23, documents R16 as a High Fall Risk with a score of 21. A score of 10 points or more equal a High-Risk Score. R16's Fall Risk Assessment, dated 9/27/23, documents R16 as a High Fall Risk with a score of 21. A score of 10 points or more equal a High-Risk Score. R16's Physician Order, dated 10/11/23, documents "Skilled OT (occupational therapy), 5X/week X 4 weeks for therapeutic exercise, ADL, therapeutic activities, and group therapy." 3. R9's Care Plan dated 10/07/2014, documented, "Assist to transfer using (full) mechanical lift with staff assistance- does not bear wt. (weight) well due to arthritis in knees." R9's Physician Order Sheet (POS) dated 10/2023, documented diagnoses of Alzheimer's, dementia, and hypertension. R9's MDS, dated 7/13/2023, documented that R9 was dependent upon 2 staff members for transferring to/from chair to bed. On 10/11/2023 at 9:30 am, V13 (CNA) and V12 (CNA) attached the full mechanical lift pad to the full mechanical lift in preparation of transferring R9. V12 operated the lift. R9's wheelchair was not locked, and V12 started to lift R9 out of the wheelchair. V13 was supporting R9 while she was being transferred. The lift pad straps were not checked prior to moving R9 away from the wheelchair and towards the bed. When R9 was lifted into the air, she was slouched down in the sling with her chin touching her chest. R9 was laid down in bed.	S9999		

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S9999	Continued From page 22 4. On 10/11/2023 at 08:25 AM, V12 and V13, (both CNAs), prepared R92 to be transferred to her reclining geriatric chair. V12 operated the full mechanical lift while V13 had hands on R92 while transferring. When R92 was just above the bed, the straps attached to the pad and to the mechanical lift were not checked prior to moving resident away from the bed. R92 was then moved towards her reclining geriatric chair, and it was pulled underneath her by V13. The chair was not locked and R92 was lowered to it and the reclining geriatric chair was freely moving side to side. R92's POS dated 9/27/2023, documented diagnoses of Alzheimer's disease with early onset and Urinary Tract Infection. R92's Baseline Care Plan dated 9/27/2023 documented "Transfer: assist of 2, (full mechanical lift)." On 10/12/202 at 3 01:00 PM, V8 (CNA) stated that when she uses the full mechanical lift, she will check the straps prior to moving a resident away from the bed or wheelchair in case the straps are not secure. V8 also stated that she would lock the bed, wheelchair, and reclining geriatric chair before transferring a resident. On 10/12/2023 at 01:15 PM, V13 (CNA) stated most of the time she would check the straps to make sure they are secure before she moves a resident away from the bed and wheelchair. V13 stated that she would lock the reclining geriatric chair or wheelchair before transferring a resident. 10/16/2023 at 8:20 AM, V2 (Director of Nurses/DON) stated that she would expect the	S9999		

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S9999	Continued From page 23 staff to check the straps to the full mechanical lift prior to moving the resident away from the bed or the wheelchair and lock the wheelchairs and reclining geriatric chairs. The facility "Fall Prevention policy" dated 11/10/2018, documented, "To provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility." It continues, "3. Assessments of Fall Risk will be completed by the admission nurse at the time of admission. Appropriate interventions will be implemented for residents determined to be at high risk at the time of admission for up to 72 hours." It continues, "5. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. 6. The unit nurse will place documentation of the circumstances of a fall in the nurses notes or on an AIM for Wellness form along with any new intervention deemed to be appropriate at the time. The unit nurse will also place any new intervention on the CNA assignment worksheet." The facility's User Instruction Manual for the Full mechanical lift, dated 7/13/2020, documented, "When a patient is two inches above the lifting surface check all sling connection points to ensure all are secure." The facility's User Instruction Manual for the Powered Patient Lift, dated 5/20/2020, documented, "When elevated a few inches off the surface of the stationary object (wheelchair, commode or bed) and before moving the patient, check again to make sure that the sling is	S9999		

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S9999	Continued From page 24 properly connected to the hooks of the hanger bar. If any attachments are not properly in place, lower the patient back onto the stationary object (wheelchair, commode or bed) and correct the problem." It continues, "Wheelchair wheel locks must be in a locked position before lowering the patient into the wheelchair for transport." (B)	S9999		