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	IL6014823	A. BUILDING: _____ B. WING _____	C 03/03/2023

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SYMPHONY SOUTH SHORE	2425 EAST 71ST STREET CHICAGO, IL 60649

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S 000	Initial Comments Complaint Investigation 2381615/IL156863 - 300.1810 Facility reported incident of 2/08/2023/IL156792 Facility reported incident of 2/10/2023/IL156798 Facility reported incident of 1/12/2023/IL155813 Facility reported incident of 2/12/2023/IL156799 Facility reported incident of 01/10/2023/IL155804	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 3): 300.1810l) Section 300.1810 Resident Record Requirements l) All Cook County facilities with Colbert Class Members shall submit to the Colbert Lead Defendant Agency, or successor Colbert Lead Defendant Agency, on a monthly basis, an accurate census of all Medicaid-eligible residents, the previous month's voluntary and involuntary discharges conducted under Section 300.3300, including any voluntary and involuntary discharges scheduled to be conducted within 48 hours after the end of the reporting month. This monthly census must be submitted on the form prescribed by the Colbert Lead Defendant Agency using secure (encrypted) email, no later than the fifth business day of each month. These Requirements were NOT MET as evidenced by: Based on interview and record review, the facility failed to submit accurate monthly census of all	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Medicaid eligible residents to Colbert Agency. This failure affected 192 out of 192 residents reviewed who are Medicaid eligible. Findings include: On 3/1/23 at 9:04 AM, V8 [Director of Social Services] stated, "I was made aware to email Medicaid eligible residents to the Colbert Agency, and I started this year 2023. I emailed December 2022 list on January 9,2023. However, on January 20, 2023, I received an email stating my December 2022 submission was incomplete. Due to the fact the I only submitted the names of the residents, and was missing information such as primary diagnosis, Medicaid health plan, date of birth, admission date, primary diagnosis, and mental health diagnosis. Also, because my submission was not completed, the email stated that an incomplete report is not counted as received. I have not submitted the corrected complete list as of today. The December 2022 list was incomplete and not counted as received. January 2023 was not submitted as well. This month of March will reflect February 2023 census information. I am still working on completing all the required information to resubmit the new list by the 5th business day of March 2023. I only submitted one list of Medicaid eligible residents on January 9, 2023." "On 3/2/23 at 10:15 AM, V1 [Administrator] stated, V1 knows about the Colbert Program and we need to submit the census of all Medicaid-eligible residents, and the previous month's voluntary and involuntary discharges. The list needs to be submitted by the 5th business day of each month. V1 was on the email from DHS. However, V1 thought V8 had made the corrections and re-submitted the report. After	S9999		

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S9999	Continued From page 2 review, V1 realized that she was left out of some of the communications from V8 and DHS. V1 said, she will make sure the census report is submitted moving forward. As of today, the December 2022, was incomplete and not counted as received, January 2023, was not submitted as well. This month of March will reflect February 2023 census information. V1 was not aware the reports were not submitted. Reviewed an email from Illinois Department of Human Services [IDHS] dated 1/20/23 to V8 read in part- Your submission was incomplete. I am attaching the instructions as well as the template to use when submitting monthly census report. When IDHS does not received completed Census and Involuntary/Voluntary Discharge Reports by the 5th business day, late, incorrect, and incomplete reports are not counted as received, unless they are corrected, completed, and submitted within the required time frame. (C) Statement of Licensure Violations (2 of 3): 300.610a) 300.1210a) 300.1210b) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the	S9999		

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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

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.

Section 300.3210 General

t) The facility shall ensure that residents are not

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S9999	Continued From page 4 subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Based on interviews, and record reviews, the facility failed to keep 5 out of 9 [R2, R3, R4, R5, R6] residents free from abuse. This failure resulted in R2 sustaining a left forehead laceration and requiring emergency room evaluation. Finding Include, On 2/28/23 at 1:56 PM, surveyor observed R2 resting in bed, alert and oriented X1, confused and unable to sound out words, or articulate sentences. R2's medical record documents in part: Admitted on 8/17/22 admitting diagnosis of dementia, peripheral vascular disease, osteoarthritis, rhabdomyolysis, and atherosclerotic heart disease. Social Service Potential for Abuse and Neglect Assessment dated 2/16/23 indicates R2 may be at risk for potential abuse related to behaviors problems as evidenced by wandering Goal R2 to remain free of harm and to monitor R2's behavior. Minimum data set brief interview for mental status score = [0] indicated severely cognitively impaired. Physician order dated -2/10/23, Left side of Head: steri strips monitor for any abnormalities check daily and as needed. Medication Administration Record for February 2023; noted physician order dated 2/10/23 -Left side of head: steri strips	S9999		

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S9999	Continued From page 5 monitor for any abnormalities check daily and as needed end dated 2/18/23. Wound care assessment details report dated 2/10/23 document in part- type [trauma], source [facility acquired], two steri strips in place holding skin together. R2's emergency evaluation documentation in part dated 2/8/23; The patient [R2] is a 78-year male with a past medical history of dementia who presents to emergency department with the chief complaint of alleged assault. Per triage notes patient [R2] arrived from facility following physical altercation with peer. Per NH [Nursing Home] staff, patient[R2] was hit over the head with a glass plate. Progress noted dated 2/8/2023, at 16:06-Health Status: Text: Pt [R2] involved in physical altercation with peer. Pt [R2] noted with laceration and raised area to left side of head. Pt [R2] has bleeding addressed, controlled and ceased. MD made aware, orders ice, and steri strips to area, send to hospital for evaluation and treatment. Ordered carried, Pt[R2] vitals present at 136/90bp [blood pressure], p84 [pulse], r20 [respirations], t97.8 [temperature], spo2 99 [oxygen saturation]. Pt [R2] denies pain, medicated prophylactically. Pt [R2] family contacted a numerous of times, all contacts on face sheet contacted with no avail, will continue to attempt. Ambulance gives one hour ETA [estimated time of arrival], hospital has report communicated too. Pt [R2] noted with staff with close monitoring. Care Plans: dated 8/22/22-R2 has severe impaired cognition required frequent cueing and redirection. Dated 8/22/22-R2 is risk for elopement related to dementia. Dated 8/22/22 R2 is confused and wanders the unit. Dated 8/22/22	S9999		

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S9999	Continued From page 6 R2 wanders into residents' rooms and take belongings; staff will monitor R2's behavior. Dated 2/8/23 R2 at risk for potential abuse related to behavior problems as evidenced by wandering, R2 involved in incident where another resident struck R2 after R2 wandered into the resident's room; R2 will remain free of harm; Assure R2 that he is in a safe and secure environment with caring professionals. On 2/28/23 at 2:00 PM, surveyor observed R1 sitting on the side of the bed, alert, and oriented X1-2. R1 was able to answer questions only for the present, he [R1] did not have any memory of the 2/8/23 incident. R1's medical record documents in part: admitted 11/1/19 with the medical diagnosis of chronic kidney disease, anemia, encephalopathy, dementia, memory deficit, and essential hypertension. Social Service Potential for Abuse and Neglect Assessment dated 2/16/23 indicates R1 has a history of aggression. Minimum data set brief interview for mental status score = [03] indicates R1 is moderately cognitively impaired. Care Plan dated 2/8/23-R1 may be a risk for potential abuse related to behavior problems as evidence by striking other individuals when they enter into his room. Progress noted dated 2/8/23 16:50-Health Status/Progress Note Text: Pt [R1] involved in physical altercation with peer [R2]. Pt noted causing laceration and raised area to left side of other patient's head. Pt [R1] noted saying, "Get out, get out, I'll end him, he came in my room, he doesn't know what he is doing, so I pushed him out.": Pt. separated immediately. Pt [R1] has no s/s of pain or injury. Pt [R1] vitals present at	S9999		

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S9999	Continued From page 7 119/72bp, p69, r18, t98, spo2 98. Pt MD made aware, orders pt. [R1] to be sent for psych evaluation. Pt family made aware. Elite gives one hour eta, pt. will be monitored until pick up. Emergency department notes:2/8/23 at 19:30 R1 was pacing back and forth, refused blood draw and R1 became verbally aggressive with staff. R1 received Haldol 5mg injection. 2/8/23 at 22:00 R1 becoming aggressive with staff. R1 received Ativan 1mg injection. On 2/28/23 at 12:08 PM, V5 (Registered Nurse) stated, "I been working here at this facility for 10 years first as a Licensed Practical Nurse, then became a Registered Nurse in 2019. On 2/8/23 I was the nurse working. I was told by the Certified Nurse Assistant [V6] that the R1 was yelling and screaming for R2 to get out his room. R2 was noted with a laceration to the side of his forehead. I cleaned the area applied steri-strips and placed ice to the area. I asked R2 what happened, he was not able to cognitively answer me. R2 is normally alert 1-2 and has never been able to explain himself to me, that is his [R2] normal cognition. The physician, family, director of nursing and administrator was made aware of the incident and injury. I received orders for the physician to send R2 to the emergency room for further evaluation. R1 told me that R2 came in his [R1] room, and R2 did not know where he[R2] was going. R1 said that he [R1] pushed R2 out of his[R1] room. R1 did not say how R2 received the laceration to his [R2] forehead, R1 just kept saying I pushed him [R2] out, I pushed him out. I never got a clear understanding how R2 received the laceration to his forehead. Both residents were separated immediately, assessed R1 did not noted any injuries to R1, however R1's physician gave order for R1 to be sent out for a	S9999		

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psych evaluation. The family, director of nursing and administrator was made aware of the incident and the order for R1 to be sent out for psych evaluation. R1 has behaviors of aggression due to non-compliance not wanting to do complete task that nursing needed him [R1] to do and becoming agitated. R2 has behaviors of pleasantly wandering around in other resident rooms, without any history of aggression."

On 2/28/23 at 12:49 PM, V6 [Restorative Certified Nurse Assistant] stated, "I worked on 2/8/23 and seen R2 walking into the employee's bathroom, I redirected R2 from the bathroom. Then I saw R1 upset telling me to keep R2 out of his room. R1 was angry, upset, and hyper. R1 said get him away from me before I end him and hurt him again. I asked R1 to calm down and I still had R2 near me. I looked at R2 and saw an open knot on the side of his [R2] forehead bleeding. I told V5 what I saw and V5 took over the situation. R2 was not able to tell me what happen. R2 is not normally able to formulate a sentence. R2 normally wanders around in other residents' room, staff tries to verbally redirect R2 out of resident's rooms. However, R2 always wander back in the rooms fidget with other resident's personal items, which can aggravate some of the other residents. R1 normally stay to himself and stay in his room. R1 is easily agitated, angry and moody. Both residents have dementia but at different progressions of dementia. R1 is alert and oriented X 2-3, he knows what he is doing at present time, but may not remember later. R2 is severely demented, he cannot put a sentence together, and do not know what he is doing at all."

On 3/1/23 at 1:11 PM, V13 [Certified Nurse Assistant] stated, "I been working here in this facility for 6 months, and I have been a certified

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nurse assistant for 4 years. R2 was my resident on that day, but I don't remember anything at all. I worked overtime that day, but I have no memory of what happened. I have received abuse training when I was hired. Some types of abuse are financial, verbal, physical, emotional, sexual, and seclusion. The abuse coordinator is the administrator."

On 3/1/23 at 1:30 PM, V16 [Licensed Practical Nurse/Wound Care Nurse] stated, "I been working her for 8 years. I picked up to work on the floor on 2/8/23 and I was the nurse for R1. During the time of the incident, I was completing wound care treatments. When I got to third floor to work as a staff nurse, both residents were on their way out to the hospital. During report from V5 there was resident to resident aggression between R1 and R2. I was told R1 hit R2, but I did not know what had happened. V5 was the nurse on the floor at the time of the incident and he [V5] completed the documentation. The next day as the treatment nurse I did assess R2's laceration to his forehead. The area was clean with two steri strips in place, and no active bleeding. I received abuse training about a month ago. Some types of abuse are verbal, physical, sexual, and mental. If abuse occurs, I will report it to the administrator."

On 3/1/23 at 1:48 PM, V5 stated, "I was R2's nurse on 2/8/23. I gave report of the incident to the ambulance [EMT] personnel when they arrived to transport R2 to the emergency room for an evaluation. I did not know what caused R2's forehead laceration. Sorry, I forgot that I did tell the EMT R2 was hit over the head with a glass plate. I did not witness the incident, but I saw the plate in R1's room, I cannot remember what made me think R2 was hit over the head with a

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glass plate. I received abuse training at least every year, sometimes more often. Some types of abuse are physical, mental, verbal, financial, and sexual. If I witness abuse, I will separate the persons and notify the administrator immediately."

On 3/2/23 at 9:00 AM, V2 [Director of Nursing] stated, "R1 and R2 abuse allegation findings was R1 pushed R2 out of his room and R2 sustained a laceration to his forehead. I was not made aware until today that the nurse told the ambulance personnel that R2 was hit over the head with a glass plate. R2 does have a history of wandering in other resident's room and elopement risk. The nursing staff is to monitor R2 closely and provide re-direction and activities to keep R2 attention occupied. The staff should at least check on R2 every hour and monitor him closely when R2 is starting to wander around the unit. R2 wandering behavior into other residents' room, when staff is not aware could potentially cause R2 to be abused by another resident."

On 3/2/23 at 10:15 AM, V1 [Administrator] stated, "The abuse investigation between R1 and R2 was substantiated. R1 stated that he pushed R2 out of his room and staff noted bleeding from R2's forehead. During my investigation, I was not told by anyone that R1 hit R2 in the forehead with a glass plate. I assume when R1 pushed R2 that he hit his head on the wall or door frame. I am not sure why V5 [Registered Nurse] told the ambulance drivers and the emergency room nurse that R2 was hit in the head with a glass plate. I think V5 assumed that because he over thinks every situation. R1 was sent out to the hospital for a psychiatric evaluation and R2 was sent out to the emergency room for an evaluation of the laceration to his forehead. Both residents'

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S9999	Continued From page 11 room are now on opposite wings of floor. All new hires receive abuse training upon hire and before they are allowed to with the residents. All other staff receives abuse training at least annually and with any abuse allegations." Policy-Documents in part dated 2/17 Abuse Prevention Program: -This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property or mistreatment of residents. ////////////////////// R3's comprehensive care plan contains a focus initiated on 10/25/2022 that documents in part that R3 may be at risk for potential abuse related to mental and emotional challenges as evidenced by diagnoses of major depressive disorder and confusion. The goal was for R3 to remain free from incident through the next review date. A facility reportable documents in part: On 02/10/2023 at 7:30 PM, R3 was struck by R4 while in [R3's] room. Staff noted a "dime-sized raised area" to the bridge of R3's nose. V15's (Physician) progress note dated 02/10/2023 8:28 PM documents in part that R3 was assaulted by another resident. R3 was hit in	S9999		

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the face. Staff reported R3's nose was swelling. V15's disposition was to transfer R3 to the hospital due to facial pain and assault.

V5's (Nurse) progress note for R3 dated 02/10/2023 8:51 PM documents in part: "Writer summoned to resident room, [V7, Certified Nurse Aide] states another patient aggressed set patient. [Patient] noted in bedroom, [patient] noted in physical altercation with another patient. [Patient] states '[R4] hit me in my nose, I got something for [R4] though,' [patients] separated, and monitored."

On 02/28/2023 at 12:27 PM, V5 stated above progress note to be true to the incident in which R4 hit R3. V5 stated R3 sustained a dime-sized bump to the nose with no report of fracture from the hospital.

On 02/28/2023 at 12:53 PM, V7 stated [V7] was providing care to R3's roommate when [V7] heard R3 state "get the f*** out of my room." When V7 pulled the curtain back to see who R3 was talking to, it was R4. V7 stated, "Before I can get there, [R4] charged at [R3] and hit [R3] in the middle of [R3's] face in [R3's] nose." V7 stated, "[R3] is the floor bully. [R3] curses people out but nothing physical." V7 stated R4 is a wanderer and gets physically aggressive at times. V7 stated, "By [R4] and [R3] being both my patients, I couldn't watch them like that. Their rooms were separated by one room." V7 stated R4 continued to be aggressive towards staff after separating the two residents. V7 stated after the incident, R3 sustained a scar at the center of [R3's] face near the nose.

On 03/01/2023 at 10:36 AM, V8 (Social Services Director) stated R3 has a behavior of cursing

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SYMPHONY SOUTH SHORE	2425 EAST 71ST STREET CHICAGO, IL 60649

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residents out. V8 stated when R3 curses, "it's meaningful but [R3] is more bark than bite." V8 stated, "[R3's] dementia is mild so [R3] has meaning behind [R3's] words." When asked about R4, V8 stated, "[R4] is more aggressive than verbal. There's more confusion. If a staff or resident approaches [R4] and [R4] doesn't know what it's about, it's more of a physical response than a verbal response." V8 stated R4 had previous aggressive incidents with staff and residents.

During a telephone interview on 03/01/2023 at 4:46 PM, V17 (Nurse) stated [V17] did the aftercare for R3's injury. V17 stated R3 had swelling to the bridge of the nose. V17 described R4 as a little aggressive at times and can come out very agitated. V17 stated it sometimes takes a lot to calm R4 down because [R4] is hard to redirect.

V17's progress note for R4 dated 02/10/2023 7:44 PM documents in part that R4 struck a lady in the nose. Facility petitioned R4 to the hospital for evaluation.

R4's comprehensive care plan contains a focus initiated on 10/20/2022 that documents in part that R4 can become combative with staff and other residents and will strike others when staff attempts to redirect or even during moment where R4 is not provoked. Comprehensive care plan did not contain a focus for R4's potential for abuse and neglect until date of the incident.

R5 and R6

R5's comprehensive care plan contains a focus initiated on 07/06/2022 that documents in part that R5 may be at risk for potential abuse related

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to mental and emotional challenges. The goal was to remain free from harm through the next review date. R5's comprehensive care plan also contains a focus initiated on 10/20/2021 that documents in part that R5 has aggressive behaviors at times, verbal and physical abuse towards residents. The goal was for R5 to keep hands to self and walk away when [R5] feels angry. R5 was to be free of aggressive behavior and speak with social services when feeling provoked.

R6's comprehensive care plan contains a focus initiated on 10/10/2022 that documents in part that R6 may be at risk for potential abuse related to mental and emotional challenges as evidenced by R6's interactions with other residents and staff members. The goal was to remain free from harm through the next review date.

Facility reportable documents in part: "On 1/12 around 5pm the elevator door open on the 4th floor when two residents were observed entangled, one of which was on the floor and the other on top. Both residents were holding each other at arm's length and yelling derogatory statements at each other." R5 yelled "I'm going to get that motherf***er, watch." R6 stated, "That's what you get for f***ing with me and I'm going to get you one day, you are going to stop playing with me."

V17's (Nurse) progress note for R5 dated 01/12/2023 4:59 PM documents in part that R5 was physically aggressive towards a fellow resident and V1 (Administrator).

V17's progress note for R6 dated 01/12/2023 5:00 PM documents in part that R6 was physically aggressive towards a fellow resident and V1.

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S9999	Continued From page 15 On 03/01/2023 at 10:36 AM, V8 (Social Services Director) described R5 as rambunctious, easily offended, and difficult to re-direct. V8 stated R5 can be verbally aggressive and abusive to both staff and residents. V8 stated R6 was also verbally aggressive at times. On 03/01/2023 at 12:24 PM, V12 (Nurse) stated R5 and R6 did not get along. During a telephone interview with V17 on 03/01/2023 at 4:46 PM, V17 stated R5 and R6 got into a physical altercation while in the elevator. V1 and staff tried to break the two up but V1 got hurt in the process. During a telephone interview with V1 on 03/02/2023 at 10:21 AM, V1 stated, "I was in the building making rounds late that evening. I was leaving the floor when the elevator door opened, and they were holding each other and going off. I screamed and tried to pull them apart. I was trying to keep [R6] from coming out of [R6's] wheelchair. [R5] looked at me and was like 'no the f*** not' and [R5] just kicked me in my face." V1 stated, "I didn't actually see them throw punches. They were kind of like in a standoff and holding each other. I don't know if they already got into it, were about to get into it or what. I don't know what stage their argument was in, but [R5] didn't want me to separate them. They still wanted to get into it with each other." V1 described both residents to have "dominating personalities." V1 stated, "I was trying to talk to them, and they were just going back and forth. They were not interview-able. They were too busy arguing. It was hard to redirect them." Facility's "Abuse Prevention Program" dated	S9999		

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S9999	Continued From page 16 02/07/2017 documents in part: "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents." (B) Statement of Licensure Violations (3 of 3): 300.610a) 300.1210b) 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. Section 300.1210 General Requirements for	S9999		

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S9999	Continued From page 17 Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to a.) ensure 2 (R7, R8) of 3 (R3) residents reviewed for falls were free from injury and b.) ensure one (R9) resident environment remains as free of accident hazards as is possible to prevent the potential for injury. These failures resulted in R7 sustaining an injury	S9999		

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requiring a suture to the left side of the head, R8 sustaining traumatic injuries with bilateral femur fractures and R9 sustaining an injury requiring three sutures to the bridge of the nose.

Findings Include:

R7 was admitted to the facility on 11/12/21 and has diagnosis not limited to Type 2 Diabetes Mellitus, Limitation of Activity Due to Disability, Hypoglycemia, Epilepsy, Cerebral Infarction, Dysphagia, Abnormalities of Gait and Mobility, Repeated Falls, Slurred Speech, Unsteadiness on Feet and Cardiac Pacemaker. R7 MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognitive response.

R7 has sustained 7 falls in 13 months with one resulting in an injury that required a suture to the left side of the head.

MDS Section G Functional Status document in part: B. Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position: Extensive Assist. Two + Person physical assist.

Care Plan document in part: Actual Fall, with actual fall on 01/20/22 @ 20:27. IDT (Interdisciplinary Team) Fall Note: Actual Fall on 06/23/22 @ 07:47, actual fall on 08/14/22, 09/22/22, 01/15/23 01/25/23, 02/12/23. Date Initiated: 08/14/22 Created on: 01/21/22. Maintain bed in the lowest position, lock wheels to prevent the bed from moving.

Progress note dated 01/20/22 at 19:45 document in part: Health Status/Progress Note Text: writer was called to R7 room by CNA (Certified Nurse

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S9999	Continued From page 19 Assistant) due to R7 being on the floor, writer noted R7 to be lying on the floor on R7 right side noted with an injury (skin tear) to R7 left thumb with blood present. Progress note dated 06/23/22 07:47 document in part: SBAR (Situation, Background, Assessment and Recommendation) Note Text: REASON FOR REPORT: recent unwitnessed fall. Progress note dated 06/24/22 09:48 document in part: Interdisciplinary Note Text: FALL NOTE: On 06/23/2022 @ 07:47 R7 had an unwitnessed fall with no injuries noted Resident was observed by staff lying in the prone position beside his bed. R7 stated that R7 rolled out of bed onto the floor on his stomach. Progress note dated 08/14/22 07:00 document in part: Health Status/Progress Note Text: Brought to writer's attention that R7 was noted on the floor in room. Writer went to room noting bed in a diagonal position, floor was wet from urine, resident noted in sitting position with back against the bed, resident noted with non-skid socks on, and wheelchair was pushed back near window. There is no documentation in the progress notes for the fall that occurred on 09/22/22. Progress note dated 01/15/23 15:10 document in part: Restorative Nursing Note Text: R7 was reported to be sitting up on the floor matt stated he was trying to get to his closet. Progress note dated 01/24/23 18:15 document in part: SBAR Note Text: REASON FOR REPORT: observed on floor in bathroom. Progress note dated 0 1/24/23 18:15 document in	S9999		

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S9999	Continued From page 20 part: Health Status/Progress Note Text: was called to R7 room, where it was observed R7 was sitting in R7 bathroom on floor. Progress note dated 02/12/23 12:15 document in part: SBAR Note Text: REASON FOR REPORT: R7 had a fall NEW ORDERS: Resident sent to E.R (Emergency Room) for Evaluation and Treatment. Progress note dated 02/12/23 17:30 document in part: Health Status/Progress Note Text: R7 return to facility from Hospital. R7 noted with 1 suture to left side of head. Fall Risk Screen dated 02/12/23 document in part: 3. History of falls within last six months 5. Multiple falls. Score 13. Document titled, "Facility Reported Incident", dated 02/13/23, for the incident that occurred on 02/12/23 document in part: 02/12/23 R7 sustained a fall while attempting to self-transfer himself from the bed to the wheelchair. R7 sent to ER (Emergency Room for evaluation and treatment. Returned to facility with one suture. On 03/01/23 at 02:12 PM R7 was observed sitting in a wheelchair in the dining room. R7 stated, "About 3-4 weeks ago I was asleep and fell out of bed. My head hit the floor and when I reached up and touched my head it was bloody. I put my hand on the floor to try to straighten up and there was blood on the floor. I called the Certified Nurse Assistant, and they made the decision that I needed to go to the hospital." On 03/01/23 at 04:26 PM V26 (Wound Care Coordinator/Licensed Practical Nurse) stated, "I was getting my laptop and the aides were passing	S9999		

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trays when housekeeping told the aide that R7 had fallen. R7 had a laceration to the left side of the head. R7 is alert and oriented x 2-3. The fall was during breakfast time."

On 03/02/23 at 10:44 AM V27 (Restorative Nurse) stated, "R7 has the interventions to call don't fall that was initiated 09/22, encouraged to wait for assistance initiated 12/13/22 and bed lowest position initiated 11/12/21. R7 is at risk for falls and has had multiple falls. The last fall with injury was on 02/12/23. R7 was sent to hospital and came back with one suture to the left side of R7 head. Per nurse documentation R7 said he was trying to get up in his (R7) wheelchair. R7 is alert and oriented x2-3 with periods of confusion. Floor mats were implemented 01/11/23 and on 01/30/23 the floor mats were resolved. When we resolve an intervention, the intervention is removed from the care plan. With the floor mats, we were trying to figure out the pros and cons. The floor mats are a tripping hazard and that's why we removed that intervention. R7 cannot walk by himself. From R7 care plan R7 had 4 falls in 2022 and has had 3 falls 01/15/23, 1/25/23 and 02/12/23. The new intervention that was added for 01/15/23 is the resident to be in common areas during hours of awake.

On 03/02/23 at 12:05 PM V2 (Director of Nursing) stated, "My expectations of the staff are to prevent falls and make sure any fall interventions are in place. R7 fell out of bed trying to get in his wheelchair.

R8 was admitted to the facility on 12/22/09 and was discharged to the hospital on 01/11/23. R8 has diagnosis not limited to Nondisplaced fracture of proximal Phalanx of Left Lesser Toe(s), Limitation of Activities Due to Disability, Muscle

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S9999	Continued From page 22 Weakness (Generalized, Reduced Mobility, Morbid Obesity, Depressive Episodes, Heart Failure and Rheumatoid Arthritis. R8 MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognitive response. MDS Section G Functional Status document in part: Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture: Extensive Assist. Two + Person physical assist. Care Plan document in part: R8 requires assist with ADL'S (Activities of Daily Living) related to Impaired Mobility, Weakness, Rheumatoid Arthritis, Carpal Tunnel Syndrome, Morbid Obesity. Mobility, Toileting, Total assist x 2 staff with Transfer, non-ambulatory. R8 is at risk for fall related to Co- Morbidities. R8's Fall Risk Screen dated 01/11/23 document in part: 3. History of falls within last six months 5. Multiple falls. Progress note dated 01/10/23 22:40 document in part: Incident Follow up note: Upon rounds, I heard the bed being lowered. Upon entering room R8 noted with bed remote lowering bed. R8 was observed half on bed with legs bent back. I immediately adjusted R8 and lowered patient to floor for safety. Bed was currently in lowest position. Resident placed in bed. ROM (Range of Motion) initiated; resident complained of pain to bilateral knees. Received new orders for x-ray. Progress note dated 01/10/23 23:59 document in part: SBAR Note Text: REASON FOR REPORT: behavior, anxious, sliding self from edge of bed.	S9999		

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S9999	Continued From page 23 Progress note dated 0 1/11/23 01:06 document in part: Incident Follow up note: resident in bed, c/o (complain of) right knee pain, resident sat up from recliner position, slid to edge of bed with c/o knee pain. Progress note dated 01/11/23 08:21 document in part: Incident Follow up note: Resident noted scooting to edge of bed. Progress note dated 01/11/23 09:30 document in part: Health Status/Progress Note: Called to room by CNA (Certified Nurse Assistant)-states she and the x-ray technician were attempting to reposition R8-R8 leaned forward and slid to floor. R8 with complaint of bilateral lower extremity pain. R8's Progress note dated 01/11/23 10:05 document in part: Health Status/Progress Note: x-ray results noted fx (Fracture) present. R8's Document titled, "Nursing Home to Hospital Transfer Form", dated 01/11/23 document in part: reason for transfer: Fall. Document titled "Report of Resident Incident/Accident dated 01/10/23 document in part: R8 sustained a fall in her room from her bed while attempting to get up. 01/11/23 X-ray results, Right knee acute oblique fracture of the distal femur. Radiology Results Report dated 01/11/23 document in part: Right Knee 1/2 views Acute oblique fracture of the distal femur. Moderate arthritic changes of the knee with acute distal femur fracture. Left Knee 1/2 views Acute oblique fracture of the distal femur. Acute distal femur fracture.	S9999		

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S9999	Continued From page 24 R8's Hospital Records dated 01/11/23 document in part: Clinical Impression: 2. Age related osteoporosis, unspecified pathological fracture presence. 3. Fall, initial encounter. Chief Complaint: Patient presents with Fracture Multiple recent falls, x-ray showed bilateral femur fractures. Fall. Lower extremities fractures confirmed by x-ray. Principle/Secondary Diagnosis: Bilateral Hip Fractures, Acute Renal Failure and Hyperkalemia. Result date: CT (Computed Tomography Scan) Lower Extremity Left: Radiographs 01/12/23 Findings: comminuted fracture of the distal meta diaphysis of the femur with approximately one shaft's-width posterior and one-half shaft's-width medial displacement of the distal fracture fragment. Fracture appears to extend to the very superior aspect of the patellofemoral articulation. CT (Computed Tomography Scan) Lower Extremity Right Findings: Redemonstrated comminuted but predominately oblique fracture of the distal meta diaphysis of the right femur with approximately one shaft's-width anterolateral displacement and anterolateral angulation of the distal fracture fragment. Procedure(s) Performed 1. Retrograde intramedullary nailing of bilateral femur fractures. On 02/28/23 at 12:58 PM V9 (Unit Manager 2nd Floor) stated, "I was checking with the hospital to follow up on R8 care and see how R8 was doing. I was not present when R8 fell, R8 had her injury when I came to the unit. They were doing an x-ray at the time of the second fall and R8 went out to the hospital. The fall incident happened with the x-ray technician. I was notified R8 had the previous fall that night before and that is why the x-ray tech was there to do an x-ray. R8 fell twice to my understanding. When I came to the floor during the x-ray, R8 had a fall, and I was there for the aftermath. I observed R8 on the	S9999		

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S9999	Continued From page 25 floor." On 02/28/23 at 01:22 PM V10 (Registered Nurse) stated, "R8 had fallen on the night shift. The x-rays were to be done on my shift and R8 had another fall when they were doing the x-ray of the bilateral knees. I don't think R8 complained of pain before sliding off the bed but R8 was complaining of Bilateral leg pain after she (R8) slid from the bed. The x-ray was completed, and the x-ray company called and reported that R8 had a thigh fracture." On 03/01/23 at 11:41 AM V18 (Nursing Manager) stated, "R8 did not like coming out of the room and would sit on the side of the bed. I worked the day that R8 fell, but I was not here when the first incident happened that morning. The initial fall happen on the midnight shift. I did assist the nurse when the x-ray tech came in and they were sending R8 out on 01/11/23. The x-ray tech came in to do R8 x-rays from the previous fall before R8 fell with the x-ray tech. I do not know what happen because I did not assist in anyway when they were x-raying R8 legs." On 03/01/23 at 02:16 PM V22 (Certified Nurse Assistant) stated, "R8 sat in bed on the side of her bed. On 01/10/23 I was not aware that R8 had fallen until the staff got R8 up. R8 fell that night and again that morning. The morning of 01/11/23 when R8 had the second fall there was a female radiology tech with R8, and the Certified Nurse Assistant made me aware that R8 had fallen." On 03/02/23 at 10:44 AM V27 (Restorative Nurse) stated on 02/12/23 hipsters to be applied while in bed. Everyone is at risk for falls. R8 was extensive 2 assist with transfers, 1 with bed	S9999		

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S9999	Continued From page 26	S9999		

mobility, and a mechanical lift. R8 was at risk for falls. On 01/11/23 R8 went to the hospital. On 01/10/23 R8 was in bed and complained of knee pain. In the documentation the nurse said she heard the bed lowering and the nurse noticed R8 halfway on the bed and R8 legs were bent back. R8 does sit on the side of the bed. I don't know if R8 would fall asleep while sitting on the side of the bed. The x-ray was completed after the second fall. I cannot determine if R8 had the fractures after the first or the second fall."

On 03/02/23 at 12:05 PM V2 (Director of Nursing) stated, "The staff gave me a call and I was told that V17 (Licensed Practical Nurse) heard R8 bed being lowered. V17 (Licensed Practical Nurse) went into R8 room and R8 was sitting on assuming the edge of the bed. R8 said she fell asleep. They positioned R8 and R8 bilateral legs were underneath her. R8 complained of pain to the bilateral knees, and they did the x-ray. The staff could not move R8 because R8 was a heavy lady and they had to put R8 on the floor to use the mechanical lift and put R8 back in the bed on 01/10/23. The X-ray tech came the next morning on 01/11/23. They reported to me that R8 sustained a fall when they were trying to reposition R8 to do the x-ray. R8 was sitting on the side of the bed. They would have had to lay R8 in the bed. When I did the original fall reportable the fractures must have come from the first fall that's why I just submitted that one."

On 03/02/23 at 02:36 PM telephone interview attempted to contact V25 (Certified Nurse Assistant) that was caring for R8 on 01/11/23 x3 with no answer. Voicemail left with return contact information.

On 03/02/23 at 02:37 PM telephone interview

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S9999	Continued From page 27 attempted to contact V17 (Licensed Practical Nurse) x2 that was caring for R8 on 01/10/23 with no answer. Voicemail left with return contact information. On 03/02/23 at 02:52 PM per telephone interview V19 (Radiology Technologist) stated on 01/11/23 when I first arrived to and entered R8 room to do the stat bilateral lower extremity x-ray R8 call light was on. R8 was sitting toward the foot of the bed with her gown hanging on her wrist and R8 chest was completely exposed. I introduced myself, adjusted R8 gown then went to get an aide to help reposition R8 in bed to do the x-ray. While waiting for the aide I started to get R8 history. R8 is a large woman and complained of pain from both legs just above the knee, more towards the lower femur. When the aide arrived to R8 room we both positioned ourselves on both sides of R8 and before we got a chance to touch R8, R8 leaned forward and shouted "oh". R8 fell to her knees, elbows and forearms then rolled to the right side. When everyone came to get R8 up, it was 4-5 staff that sat R8 up. Two of the staff members grabbed R8 under each arm and two staff grabbed R8 by the lower part of the leg and transferred R8 to the bed. They did not us a mechanical lift. I was able to do some of the x-rays and I did partial views. A new order was entered after R8 fell the second time they added on the right lower leg, it was just bilateral knees, the right humerus and right forearm." R9 was admitted to the facility on 09/26/22 with diagnosis not limited Dyspnea, Type 2 Diabetes Mellitus, Acute Kidney Failure, Heart Failure and Abnormal Posture. R9 MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognitive response. MDS Section G Functional Status document in	S9999		

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S9999	Continued From page 28 part: Walk in room - how resident walks between locations in his/her room: Supervision. Care Plan document in part: Potential for falls, R9 at risk for injury from falls. R9 sustained fall on 01/24/23 r/t (Related to) poor safety awareness. Document titled "Facility Reported Incident dated 01/24/23 document in part: On 01/24/23 approximate time 1835. R9 attempted to retrieve his clothes from his bedroom closet, lost his balance and sustained a fall. New order to send resident to ER (Emergency Room) for evaluation and treatment. 01/25/23 patient returned with 3 sutures to bridge of nose. Hospital Record dated 01/24/23 document in part: Laceration, Head Injury. On 02/28/23 at 12:58 PM V9 (Unit Manager 2nd Floor) stated, "V17 (Licensed Practical Nurse) was the night nurse. I did not witness R9 fall. Everybody was changing rooms that day. When I talked to R9, R9 said that he was reaching into the closet and stepped on the drawer inside of the closet. R9 stated something fell off the top shelf and hit him in the face and R9 had an opening to the bridge of his nose. R9 was sent out to the hospital got sutures and was sent back to the facility the same day." On 03/01/23 at 09:10 AM R9 was observed sitting on the bed. Two board were observed being stored on top of the closet cabinet with one board extending beyond the left edge positioned over the head of R9 bed. R9 stated they had to move me from the other room that I was in. They were taking too long, and I was pulling stuff out of the top of the closet cabinet, and I could not see on	S9999		

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S9999	Continued From page 29 the top shelf. I was trying to help them out so that they could move me out of the room. I had pulled everything out of the closet except for the top shelf. The whole closet cabinet fell. The closet cabinet was not anchored to the wall. The back of my head hit the floor and I had a cut on my nose that I had to get 3 sutures. The nurses told me not to mess with the two boards that are now on the top of the cabinet closet. The boards on top of the cabinet closet are not safe and they could fall. My bed is directly below where the board would fall." On 03/01/23 at 09:40 AM the surveyor entered R9 room with V11 (Maintenance Director). Surveyor asked V11 what were the objects that were located on top of the closet cabinet next to R9 bed. V11 stated, "That looks like the cork board and mirror. They were remodeling and have not put them back on the wall. They put R9 in this room too soon, we were not finished." Surveyor asked V11 what could potentially happen with the cork board and mirror being stored on top of the closet cabinet. V11 responded, "Ma'am an accident in process. The closet cabinets are not anchored to the walls. We do not have instructions for instillation because the closet cabinets have been here for the duration of the building. Thank you for bringing that to my attention." V11 proceeded to remove the cork board and mirror from the top of R9 closet cabinet. On 03/01/23 at 01:11 PM V21 (Licensed Practical Nurse) stated, "I was not a witness when R9 fell. I was called to the room and when I went to R9 room I assessed R9 lying on floor. R9 was transferring to another room and was climbing in the closet to get something off the top shelf of the	S9999		

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S9999	Continued From page 30 closet. The entire closet fell and was beside R9. R9 ending up having a laceration across the bridge of the nose, went to hospital and had to get sutures." On 03/01/23 at 06:21 PM per telephone interview V23 (Certified Nurse Assistant) stated, "R9 told me that he (R9) was standing with the closet open trying to get the items on top of the closet and the closet came down and hit R9 in the face. I did not witness the fall but R9 had a laceration to the bridge of his (R9) nose." On 03/02/23 at 10:31 AM V24 (Licensed Practical Nurse) stated, "R9 stated that he was trying to get something off the top of the closet and the closet fell and hit him. I believe the closet fell over and I saw it on the floor. R9 had bleeding and an open cut on the bridge of R9 nose." On 03/02/23 at 12:05 PM V2 (Director of Nursing) stated, "My expectations of the staff are to prevent falls and make sure any fall interventions are in place. We were doing a room change and R9 was trying to reach something on the top shelf of his closet. The shelf or part of the dresser hit R9 on the bridge of the nose. The administrator had the maintenance make sure the shelves were intact. There could be a potential for injury with the cork board and the mirror being stored on top of the closet." On 03/02/23 at 12:53 PM V11 (Maintenance Director) stated, "I can see the shelves coming down in the closet cabinet, so I removed the shelves. The shelf lines up with the bridge of R9 nose.	S9999		

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S9999	Continued From page 31 Document titled "Facility Assessment Tool" reviewed 12/23/22 document in part: Physical environment and building/plant needs: Physical Resource Category: Physical equipment, room, and common space furniture. The facility maintenance and administrative team conduct visual inspections of the facility equipment during scheduled and random rounds. Maintenance and/or corrective actions are implemented based upon the outcome of rounds/inspections. Policy: Titled "Falls Management" review date 02/23 document in part: General: This facility is committed to maximizing each resident's physical, mental and psychosocial wellbeing. While preventing falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. Fall prevention Guidelines for all residents upon Admission/Re-admission: 2. Residents at risk for falls will have Fall Risk identified on the interim plan of care with interventions implemented to minimize fall risk. Titled "Preventive Maintenance and Inspection" undated document in part: I. Policy Guidelines: To provide a safe environment for residents, employees, and visitors a preventive maintenance program has been implemented to promote the maintenance of equipment in a state of good repair and condition. Regular inspection, testing and replacement or repair of equipment and operational systems contribute to preservation of equipment and facilities assets. II.	S9999		

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S9999	Continued From page 32 Definitions: Preventive Maintenance is the care and servicing by personnel for the purpose of maintaining equipment and facilities in a satisfactory operating condition by providing for systemic inspection, detection, and correction of incipient failures either before they occur or before they develop into major defects. C. Inspections: 1. A schedule is developed to delineate all inspections that are to be completed on a regular basis. Inspections verify that all equipment and furnishings are in working order and free from safety hazards. (A)	S9999		