STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014856	A. BUILDING: _____ B. WING _____	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT WINDSOR PARK	2649 EAST 75TH ST CHICAGO, IL 60649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1210b) 300.1210c) 300.1210d)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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 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 observations, interviews and review of records the facility failed to follow treatment per physician orders of a sacral pressure ulcers for 2 residents (R31 and R35) out of 35 residents reviewed for pressure ulcer treatment and prevention. These failures resulted in worsening of sacral pressure ulcer for R31 and R35 and opening of new wound for R31. Findings include:	S9999		

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S9999	Continued From page 2 1. R31 is 61 years old, initially admitted on 6/16/2022. R31's brief interview for mental status dated 12/21/2022 is 12 that means R31 cognition borders from being intact and moderately impaired. R31 medical diagnosis includes pressure ulcer stage 4, sepsis and Osteomyelitis of Vertebra, Sacral and Sacrococcygeal Region. Review of R31's sacral treatment orders dated 9/15/2022 to present are as follows: Cleanse sacrum with normal saline or wound cleanser. Protect peri wound with skin prep, then apply calcium alginate and cover with dry dressing. On 01/11/2023 at 11:17 AM. With V29 (Wound Care Coordinator) said, "Yes, R31 and R35 wounds worsened a little bit." However, V29 was unable to answer questions about resident pressure ulcers. V29 then said that she will print R31 and R35 orders. V29 then left the conference room and did not come back after multiple requests (V29 and surveyor spoke in the confrerence room). After review of R31's and R35's TAR for December 2022 and January 2023, multiple dates of treatment were initialed by V29 (Wound Coordinator) that was not present during review on 1/10/2023. R31's Treatment Administration Record for December 2022 reads that 17 days was not signed as treatment was performed. On 1/11/2023 at 11:46 AM, V29 came back and said that she signed treatment administration record (TAR) that was not previously signed for both residents (R31 and R35) for December 2022 and January 2023. V29 modified R31 and R35's TAR's after the surveyor asked for them to be printed and already saw the missing treatments. At 3:50 PM. V2 (Director of Nursing) was informed about modification of V29 putting her initial to treatment administration record today for dates that are in the past that	S9999		

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S9999	Continued From page 3 extend up to December 2022 for both R31 and R35. V2 said, "Yes, I was informed about that, and we will do something about it. But as to not documenting treatment or signing treatment, in nursing what is not documented is not done. Pressure ulcers has been identified as a problem and that we need to improve in that area." R31's sacral pressure injury wound assessments worsen and increased in size as to facility and physician assessment by V41 (Wound Doctor). Facility Wound Assessment of R31's sacral pressure injury are as follows: Pressure injury assessment dated 12/13/2022 has a measurement of 4.3 by 4.4 centimeters (length by width) depth was documented as unapplicable. Total area of the pressure injury was 14.6 cm2 (square centimeter). Pressure injury assessment dated 12/21/2022 has a measurement of 5.1 by 5.5 by 0.5 centimeters (length by width by width). Total area of the pressure injury was 23.2 cm2 (square centimeter). Pressure injury assessment dated 12/27/2022 has a measurement of 6.1 by 5.6 by 0.7 centimeters (length by width by width). Total area of the pressure injury was 23.2 cm2 (square centimeter). V41 (Wound Doctor) assessment for R31 sacral wound are as follows: Pressure injury assessment dated 12/15/2022 has a measurement of 4.3 by 4.4 by 0.5 centimeter (length by width by width). Total area of the pressure injury was 14.86 cm2 (square	S9999		

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S9999	Continued From page 4 centimeter). Pressure injury assessment dated 12/22/2022 has a measurement of 5.1 by 5.5 by 0.5 centimeter (length by width by width). Total area of the pressure injury was 22.03 cm2 (square centimeter). Pressure injury assessment dated 12/29/2022 has a measurement of 6.2 by 6.9 by 1 centimeter (length by width by width). Total area of the pressure injury was 26.829 cm2 (square centimeter). Pressure injury assessment dated 01/05/2023 has a measurement of 6.2 by 6.9 by 1 centimeter (length by width by width). Total area of the pressure injury was 33.599 cm2 (square centimeter). R31's sacral pressure injury wound assessments worsen and increased in size as to facility and physician assessment by V41 (Wound Doctor). Facility assessment dated 12/13/2022 to 12/27/2022 increased in size, from 14.6 cm2 (square centimeter) to 23.2 cm2 (square centimeter). And V41 (Wound Doctor) assessment dated 12/15/2022 to 1/5/2023 increased in size, from 14.86 cm2 (square centimeter) to 33.599 cm2 (square centimeter) more than doubled. R31's wound worsened and increased in size on the December 2022 TAR, where treatment on the TAR (Treatment Administration Record) was not signed as being performed as ordered by physician. On 1/11/2023 at 02:22 PM. R31 was seen with V29 inside the room. R31 was alert and verbally	S9999		

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S9999	Continued From page 5	S9999		

able to express his thoughts. V29 with the use of cotton tip and paper measuring tape measured R31's pressure injury. V29 said, "These are the measurement of R31's pressure ulcer, 8 centimeter in length, 10 centimeter in width and 1.5 centimeter in depth (after placing the cotton tip at the bed of the pressure injury)." Then V29 pushed the cotton tip inside R29's pressure ulcer at the upper right area. V29 then said, "Yes, there is an undermining from 12 o'clock to 2 o'clock." Sacral pressure injury appears to be red, swollen, with drainage, also showing white color bone-like appearance around 2 by 2 centimeters length and width. Surveyor noticed a new wound in the left buttock with serosanguinous fluid in moderate amount. V29 then said, "Yes, this is a new wound. I will measure it." Then V29 said, "This is the measurements of R31's new pressure ulcer, 0.8 by 1.5 centimeters that length by width."

2. R35 is 94 years old, with medical diagnosis of Cerebral Infarction initially admitted on 12/12/2022. R35's brief interview for mental status dated 12/13/2022 was 12 that means R35 cognition borders from being intact and moderately impaired. R35 was seen on 1/10/2023 at 11:21 AM inside dining room alert and able to verbalize thoughts during conversation. R35 said that she has wound in her buttocks area. When asked if treatment was being done to her wound. R35 said, "No, I don't remember if anyone did something on my wound."

On 1/10/2023 review of R35's treatment on her sacral wound are as follows: R35 has physician order dated 12/13/2022 until 1/5/2023 for hydrocolloid dressing after cleansing with normal saline. This order was changed on 1/5/2023 for bordered foam dressing after cleansing with normal saline that still active currently. R35's

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S9999	Continued From page 6 treatment administration record (TAR) which document every time treatment is perform per physician was not signed as being performed from 1/5/2023 to 1/10/2023. R35's sacral pressure injury wound assessments worsen and increased in size as to facility and physician assessment by V41 (Wound Doctor). Facility Wound Assessment of R35's sacral pressure injury are as follows: Pressure injury assessment dated 12/28/2022 has a measurement of 2.2 by 3.4 centimeters (length by width) depth was documented as unapplicable. Total area of the pressure injury was 4.5 cm2 (square centimeter). Pressure injury assessment dated 01/03/2023 has a measurement of 2.5 by 3.1 by 0.2 centimeters (length by width by width). Total area of the pressure injury was 4.8 cm2 (square centimeter). Pressure injury assessment dated 01/10/2023 has a measurement of 3.0 by 6.3 by 0.2 centimeters (length by width by width). Total area of the pressure injury was 7.1 cm2 (square centimeter). V41 (Wound Doctor) assessment for R35 sacral wound are as follows: Pressure injury assessment dated 12/29/2022 has a measurement of 2.2 by 3.5 by 1 centimeter (length by width by width). Total area of the pressure injury was 6.048 cm2 (square centimeter).	S9999		

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S9999	Continued From page 7 Pressure injury assessment dated 01/05/2023 has a measurement of 2.6 by 3.1 by 0.2 centimeter (length by width by width). Total area of the pressure injury was 6.33 cm2 (square centimeter). Pressure injury assessment dated 01/12/2023 has a measurement of 5.0 by 8.0 by 0.2 centimeter (length by width by width). Total area of the pressure injury was 31.416 cm2 (square centimeter). R35's sacral pressure injury wound assessments worsened and increased in size as to facility and physician assessment by V41 (Wound Doctor). Facility assessment dated 12/28/2022 to 1/10/2023 increased in size, from 4.5 cm2 (square centimeter) to 7.1 cm2 (square centimeter). And V41 (Wound Doctor) assessment dated 12/29/2022 to 1/12/2023 increased in size, from 6.048 cm2 (square centimeter) to 31.416 cm2 (square centimeter) more than 5 times increased in size. Per treatment administration record (TAR) physician order for treatment of sacral pressure injury dated 01/05/2023 to clean sacral pressure injury and cover with bordered foam dressing was not signed as treatment was being performed from 01/05/2023 to 01/10/2023 the same time pressure ulcer worsened. On 1/11/2023 at 02:38 PM. R35 was seen with V29 inside the room. R35 was alert and verbally able to express his thoughts. V29 with the use of cotton tip and paper measuring tape measured R35's pressure injury. V29 said, "R35's wound has 5 centimeters length and 8.2 centimeters width. I put wound depth at 0.2 centimeter." R35 pressure injury appears to be red, swollen, with serosanguinous drainage.	S9999		

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S9999	Continued From page 8 On 01/12/23 at 10:25 AM. V29 (Wound Coordinator) stated that both R31 and R35 sacral pressure sores increased in size. V29 further stated that part of the reason was incontinence, and it should be care planned. V29 denies doing the care plan, stated that R31's care plan does not include that she (R31) has pressure ulcer. V29 again admitted on signing treatments that was not signed. V29 stated that she modified orders, and signed treatment administration records because she was behind on her work. Admitted on signing treatments that was not signed for both R31 and R35. Skin Protection Guideline Policy dated 7/7/2021 in part, reads: The purpose is to provide evidenced based practice standards for the care and treatment of skin. To ensure residents that admit and reside at the facility are evaluated and provided individualized interventions to prevent, reduced and treat skin breakdown. Policy does not include pressure ulcer documentation. After multiple requests for Wound pressure ulcer policy including procedure documentation or how to properly document treatments. On 01/12/2023 at 6:02 PM. V16 (Nurse Consultant / Registered Nurse) said that facility does not have policy specific to proper documentation of wound treatment. V16 further said that issues regarding wound documentation including treatment documentation was identified as a problem and would help if they have the policy. (B)	S9999		

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S9999	Continued From page 9 Statement of Licensure Violations (2 of 2) 300.610a) 300.1210b)4) 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 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.	S9999		

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S9999	Continued From page 10 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. 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 provide adequate supervision for 2 (R3, R151) residents out of a total sample of 35 residents. This failure resulted	S9999		

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S9999	Continued From page 11	S9999		

in R3 sustaining a left forearm fracture.

Findings include:

1. On 01/11/2023 at 09:38 AM, surveyor entered R3's room for an interview. R3 was alert and oriented to person, place, time, and situation. R3 stated [R3] fell sometime in the evening during late summer. R3 reported sustaining a left arm fracture from the fall. R3 stated V32 (CNA, Certified Nurse Aide) was providing incontinence care. R3 stated V32 positioned [R3] on left side facing the window. V32 left R3 and went to the bathroom to run the water in the sink and wait for it to get warm. R3 stated V32 told [R3] not to move but [R3] was having a hard time staying in place due to having a large, loose bowel movement and being too close to the edge of the bed. R3 stated while V32 was coming back from the bathroom, R3 slipped out of the bed and fell on the floor. R3 stated [R3] could not hold onto anything because [R3] doesn't have bedrails and was too close to the edge of the bed. R3 stated [R3] can lift left arm but right arm is weaker. Observed R3 lift left arm to shoulder height vs right arm which [R3] cannot lift as high.

At 12:15 PM, surveyor reviewed facility's "IDPH (Illinois Department of Public Health Incident Report Form" for 08/26/2022 incident. It documents in part that R3 experienced a fall while in bed. R3 complained of left forearm pain. Left forearm and wrist x-ray resulted in possible acute fracture. R3 sent to the hospital for further evaluation.

Facility's radiology report documents in part an x-ray of left forearm with examination date of 08/27/2022. Findings document in part: "There is acute fracture in the middle third of the radius

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S9999	Continued From page 12 with moderate displacement and angulation." R3's hospital paperwork from 08/27/2022 hospital admission documents in part an x-ray of left forearm. "Findings: There is an oblique minimally comminuted mildly displaced fracture of the mid shaft of the radius. Chronic deformity of the distal radius and ulna are seen with a suspected superimposed acute fracture involving the distal ulnar metaphysis. Soft tissue swelling is seen." At 12:26 PM, surveyor reviewed R3's progress notes. V30's (Nurse) progress note dated 08/26/2022 8:49 PM documents in part: "When asked how did [R3] fall from bed resident stated that [R3] tried to grab on to side of bed to hold [R3] to side while waiting for CNA and rolled to floor, resident denied hitting head or face." At 12:30 PM, surveyor reviewed R3's Quarterly MDS (Minimum Data Set) Assessment dated 08/10/2022. It documents in part that R3 requires extensive assistance with two plus persons physical assist for bed mobility and toilet use. At 01:30 PM, surveyor conducted a follow-up interview with R3. R3 stated it was only one CNA, V32, assisting [R3] with incontinence care. R3 was laying on left side. R3 had right arm across chest and was laying on left arm. R3 was not holding onto anything. R3 stated [R3] was having a hard time staying in place on [R3's] side. R3 stated [R3] was positioned too close to the edge of the bed. R3 stated V32 already placed [R3] on [R3's] left side but R3 continued to have a bowel movement so V32 went to the bathroom to get the water going. R3 stated V32 told [R3] not to move and to stay in place but [R3] could not. R3 stated [R3] called V32 to let [V32] know R3 was falling. V32 was on the way back to R3 but V32	S9999		

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S9999	Continued From page 13 was too late because R3 fell. On 01/12/2023 at 09:55 AM, surveyor interviewed V31 (Restorative Nurse). V31 stated R3 requires extensive assistance with bed mobility. V31 stated R3 has about 65% functional strength in arms. Turning from side to side would require 75% effort from staff for positioning. V31 stated with bed mobility, R3 does about 15-30% of the work. V31 stated a CNA is not supposed to walk away from R3 while performing incontinence care and while R3 is laying on one side. Facility's "Fall Evaluation Safety Guideline" policy effective 11/28/2017 documents in part: "The intent of this guideline is the ensure this facility provides an environment that is free from hazards over which the facility has control and provides appropriate supervision to each resident as identified through the following process: i. Identification of hazards and risks ii. Evaluation iii. Implementation iv. Monitoring v. Analysis" 2. R151 has diagnosis not limited to History of Falls, Cerebral Infarction, Type 2 Diabetes Mellitus, Encephalopathy, Heart Failure, Chronic Kidney Disease, Abnormalities of gait and Mobility, Dysphasia, Weakness, Lack of Coordination, Cognitive Communication Deficit, Conversion Disorder with Seizures or Convulsions, Dementia, Hyperlipidemia, Essential (Primary) Hypertension and Atherosclerotic Heart. MDS (Minimum Data Set) Section C Cognitive Patterns document in part: Cognitive Skills for Daily Decision Making 3. Severely impaired - never/rarely made decisions.	S9999		

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	IL6014856	A. BUILDING: _____ B. WING _____	01/13/2023

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S9999	Continued From page 14 Care Plan The resident has a communication problem and has unclear speech/is primarily non-verbal however, is sometimes understood and sometimes understands AEB (As Evidenced By) making appropriate sounds/gestures and nodding his (R151) head appropriately. Date Initiated: 09/27/22. Anticipate and meet the resident's needs. Ask yes/no questions in order to determine the resident's needs. Date Initiated: 09/27/2022. The resident displays cognitive impairment with impaired thought processes as r/t (related to) DX: (Diagnosis) Dementia. Date Initiated: 09/27/22. BED MOBILITY: Bed Mobility - Resident has a self-care deficit in bed mobility related to (decrease ability to position or re-position self in bed, turn from side to side, push self-up in bed, moves from lying to sitting position. R151 requires (specify) assist for bed mobility Date Initiated: 10/07/22. The resident displays behavior of resistance to care, symptoms are manifested by agitation, refusing medication, refusing care, combative and physically aggressive towards staff i.e. (Example) (yelling, swinging and hitting staff during care provision, smearing feces). Date Initiated: 09/27/22. Use the buddy system when providing care and give clear explanation of all care activities prior to and as they occur during each contact to promote comfort during care. Date Initiated: 09/27/22. R151 is at risk for falls r/t confusion and non-compliance with staff. Actual Fall: 01.10.23 Date Initiated: 09/27/22. On 01/10/23 at 12:05 PM, during the facility tour R151 room door was observed closed. Surveyor knocked on R151 door and heard R151 moan. Surveyor opened the door and observed R151 on the floor lying on the left side next to the mattress on the floor. Surveyor informed staff that R151	S9999		

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S9999	Continued From page 15 was on the floor. On 01/10/23 at 12:15 PM, V14 (Restorative Tech) exited R151 room and stated "R151 has behaviors and do not listen. The aide was trying to get R151 up earlier. R151 was slightly aggressive, and I encourage the staff to walk away and come back later. R151 is up in the wheelchair now." On 01/10/23 at 12:19 PM, R151 was observed up in the wheelchair On 01/10/23 at 12:40 PM, V16 (Registered Nurse) stated "I think we are going to send R151 out." The Nurse Practitioner was observed in hall with stethoscope to R151 chest. V15 (Registered Nurse) stated we are sending R151 out for an unwitnessed fall and change in condition. R151 is not swallowing and pocketing food. R151 will be evaluated for that as well." On 01/11/22 at 11:06 AM, V19 (Certified Nurse Assistant) stated "I have worked here for 5 months. V19 stated I have not work with R151 that much. R151 like to grab and can get combative. R151 is a fall risk, and we constantly try to monitor R151, sometime the entire eight-hour shift. R151 will get out of the bed at times and onto the floor. R151 is alert and can communicate his (R151) needs. When I did my first rounds R151 trunk was on the mattress but the lower body from the hips was on the floor, and I assisted R151 back onto the mattress. Thirty minutes later R151 whole body was completely on the floor beside the mattress. I put R151 back on the mattress and notified the nurse. The third time about 20 - 30 minutes later R151 upper tarsal was on the mattress and R151 lower body from the hips was on the floor. I	S9999		

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S9999	Continued From page 16	S9999		

assisted R151 back onto the mattress. R151 has behaviors of getting off of the mattress and onto the floor himself. I had already been in R151 room to put R151 back on the mattress. Periodically I was going back to check on R151. I was going to get R151 up, but it would be after lunch. R151 was partially dressed because when I was doing patient care R151 could not stand up because R151 was weak. If I would have put R151 up in the wheelchair R151 would not have been able to sit up. R151 mattress has been on the floor since I have been working on this floor. R151 is normally talkative, busy and is normally up in the wheelchair. It's been a change in R151 mental status."

On 01/11/23 at 11:28 AM, V15 (Registered Nurse) stated "I was not made aware that R151 was on the floor prior to being notified that R151 was observed on the floor. R151 was a little weaker but the pocketing of the food was new for me. R151 was not up in the wheelchair because V19 (Certified Nurse Assistant) said that R151 was sleeping. We usually get R151 up. V19 (Certified Nurse Assistant) let me know that she V19 (Certified Nurse Assistant) had checked on R151 three times. When I observed R151 on the floor, R151 head was facing what would be considered the foot of the bed. R151 had no injuries. R151 require assistance. It is considered a fall when a resident body touches the floor, a change in plane. If there is an unwitnessed fall the resident is assessed, ask them what happen, notify the doctor/family, and carry out the doctor orders. R151 said that he (R151) rolled out of the bed. R151 is alert and oriented x 1-2."

On 01/12/23 at 10:17 AM, V31 (Restorative Director) stated "I was made aware of R151 fall when R151 was getting ready to be sent out to

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S9999	Continued From page 17	S9999		

the hospital. R151 was being sent out because R151 was found on the floor. To my knowledge this was R151 first fall. I am not aware of a fall on 11/13/22. I should have been informed of the fall so that I could have figured out interventions like moving R151 close to the nurse station, getting R151 up in the dining room, activities, and close monitoring. R151 room is still down the hallway. I would be the one to update the care plan. R151 should have had the interventions on the care plan updated. R151 has behaviors and may have gotten down and crawled. I am not certain if it was a fall. A fall is a change in plane, maybe from a higher level to a lower level. I was not aware that R151 mattress was on the floor."

On 01/12/23 at 10:31 AM, R151 was observed lying in a low bed with a matt on the floor next to the bed.
01/12/23 at 09:06 AM, V2 (Director of Nursing) stated "The incident with R151, we have R151 in the lowest position and the mat is on the floor. R151 is a high fall risk and R151 is able to move his (R151) extremities. The aide will go in and reposition R151. A fall is a change in plane. R151 has known documented behaviors. The Certified Nurse Assistant finding F151 off the matt one time adjust but the second time R151 should have been gotten up. R151 would have been brought to the common area or by the nurse station. That was a lack of understanding for the aide. My expectation, if a resident is a fall risk, I would get R151 up and speak to restorative or the nurse. After finding R151 off of the matt the second time I would have gotten R151 up."

Progress note dated 01/10/23 12:30, document in part: *Fall Note Text: Writer called to room due to patient noted on the floor on the side of the bed. Patient asked by writer what happened, patient

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S9999	Continued From page 18 stated "I rolled on the floor". Writer asked patient did he fall, resident replied no I rolled. Patient assisted in chair and placed in the dining room for lunch. During mealtime patient noted pocketing food and spitting up fluids. NP (Nurse Practitioner) made aware, and patient assessed by NP, new orders received to send resident out to Hospital for change in condition and also for further evaluation due to patient noted on the floor. Progress note dated 01/11/23 14:32 document in part: *Health Status Note (nurses note) Note Text: Patient A/O X's 1. Patient returned from hospital via ambulance 01/10/23 @ 4pm. Record review document R151 prior hospitalization for a fall occurred on 11/13/22 due to a fall. Policy: Titled "Fall Evaluation Guideline" effective date 11/28/17 document in part: Purpose: to consistently identify and evaluate residents at risk for falls. To prevent and reduce injuries related to falls. Falling is an unintentional change in position coming to rest on the ground floor or onto the next lower surface. Falls include any fall regardless which setting it may have occurred. The intent of this guideline is the ensure this facility provides an environment that is free from hazards over which the facility has control and provides appropriate supervision to each resident as identified through the following process: I. Identification of hazards and risks, II. Evaluation, III. Implementation, IV. Monitoring, V. Analysis. A fall evaluation is used to identify individuals who have predicting factors for falls. This evaluation is completed upon admission, quarterly, annually and with a significant change in condition. Fall	S9999		

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S9999	Continued From page 19 prevention is achieved through an IDT (Interdisciplinary Team) approach of managing predicting factors and implementing appropriate interventions to reduce risk for falls. Involve Interdisciplinary team on: Need for supervision, Development, and implementation of interventions to reduce accidents. Fall Management: Develop and implement interventions, Ongoing evaluation of effectiveness of interventions. Residents who are evaluated as being at risk for falls will be identified and individualized fall precautions will be developed for each resident. Purpose: 3. To prevent or reduce injuries related to falls. 6. Individualize interventions for each resident. Guidelines for Evaluation May include Procedure: 2. If the evaluation finds the resident at risk, implement resident specific interventions/precautions. 3. Initiate, review and revise the fall care pan as appropriate, with new or discontinued interventions. 4. The Interdisciplinary team (IDT) will evaluate the resident's fall risk in conjunction with the care plan to develop, review and revise at a minimum quarterly with increased frequency as needed to reduce resident falls. 8. All residents identified as at risk for falls will be reviewed for individualized interventions. (B)	S9999		