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S 000	Initial Comments Complaint Investigation 2392098/IL157480 - 2391722/IL156991 - 2392023/IL157424 - 2392213/IL157626 - Facility Reported Incident of 02/14/23/IL156917	S 000		
S9999	Final Observations Statement of Licensure Violations: 1/2 300.1210b) 300.1210d)6) 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. Section 300.1210 General Requirements for Nursing and Personal Care 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 and assistance to prevent accidents. These regulations were not met as evidenced by: Based on interview and record review, the facility failed to have effective care plans and interventions in place to adequately monitor residents with known history of substance abuse behaviors and failed to have an effective plan in place to keep illegal drugs out of the facility; the facility also failed to have effective, resident-centered, fall interventions in place for residents that are known to be high risk for falls to prevent residents from having repeated falls in the facility. These failures applied to R4, R6, of five residents reviewed for accidents and supervision and resulted in R4 having obtained illegal drugs which were found in R4's room; resulted in R6 not having plan in place to monitor the resident with a known behaviors of using illegal substances while at a previous facility. Findings include: R4 is a 47-year-old male who was admitted to the facility on 2/9/2023, with medical history including, but not limited to Multiple sclerosis, other abnormalities of gait and mobility, abnormal posture, weakness, other lack of coordination, major depressive disorder, low back pain, borderline personality disorder, cannabis abuse, etc. R4 is no longer at the facility during the investigation and could not be observed or interviewed.	S9999		

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S9999	Continued From page 2 Review of resident's medical record show the following documentations: R4 is a 47-year male with hx MS wheelchair bound, tobacco abuse, chronic Back pain- on baclofen pump, depression, HTN, HL, cannabis use, cocaine use, who presents for evaluation of abdominal pain (Hospital record (2/3/2023). Marijuana odor coming from resident room; upon investigation with a C.N.A present noted several cigarettes with substance rolled in them, confiscate with other paraphernalia, and placed in bag to turn over to Administrator. (Nurse's note 3/7/2023). Discovered Cannabis in res. motorized chair cargo purse and refused to give it to the writer. Social worker witnessed the situation, talked to the resident, and finally took the substance from the res. Resident was upset and wants to leave AMA but according to SW not among the family member that he called does want to pick him up. Doctor and Administrator made aware. (Nurse's note 3/8/2023). Res appears as intoxicated this am, noted with nodding, slurred speech, inability to articulate thoughts into words, nodding off in mid-sentence, eyes glossy, staring blankly at time, easily arousable from nodding, Doctor informed of situation, gave orders to hold medications. T:98.1, P:92, @21, BP:116/63, SPO2:97% R/A. Resident's sister called to facility and informed as well. (Nurse's note 3/10/2023). Progress note date 3/10/2023 documents the following: Resident noted to be having a conversation instructing someone to bring something to him by way of resident room window. Management alerted of this and continuous monitoring of outside area and resident room. A gentleman approached the window area and police were notified. The resident does not consent to search	S9999		

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currently. The man left the area immediately. The man came back to the facility about an hour later and police were able to escort him from the grounds and told him if he came back, he would be arrested for trespassing.

Review of physician order summary for R4 does not show any order for resident to use any illegal drugs while at the facility.

Facility admission assessment dated 2/9/2023 stated that resident requires extensive to maximum assistance from staff for all Activities of Daily Living (ADLS). Minimum Data Set (MDS) assessment dated 2/12/2023 section G (functional status) coded R4 as requiring supervision for locomotion on and off unit.

R4 does not have any care plan or interventions in place for the management of his substance abuse, and there is no documentation of any behavioral program/activity offered to him at the facility.

On 3/21/2023 at 1:56PM, V18 (LPN) said that she is familiar with R4, one day resident appeared intoxicated, his face was flushed like he was under the influence of drugs. R4 has a history of substance abuse, she has heard report of residents doing drugs but has not witnessed it, management is aware of the drug issue. V18 also said that R4 cannot go out to the community independently; he has gone to an outside appointment with a friend. Resident does not have appropriate supervision and need some heavy one, could be one to one if possible but cannot get such supervision here.

At 2:51PM, V5, (social service director) said that the facility lately has behavior issues related to

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S9999	Continued From page 4 illegal substance abuse and some residents coming back from outside visits under the influence. V5 said that the protocol is to let somebody know if you suspect that someone was using illegal drug, you can conduct a search with the resident's consent and have them sign a behavior contract which really does not stop them from using the drug. 3/21/2023 at 3:45PM, V20 (RN) said that she recalls R4, he is a smoker, usually goes out with staff and other residents. V20 said that she discovered cannabis on resident one time, she told him he cannot have it because he does not have an order for it, she gave the drugs to social service who intervened, resident was upset, the administrator was made aware. 3/22/2023, V3 (DON) said that R4 has been caught smoking cigarette in his room, they have also found him smoking "weed" and staff has also found him with cocaine. R4 has a behavior of being agitated if he does not get his way, he is dependent on staff and requires supervision for most ADLs as well as for smoking but sometimes he will not wait for staff, stating that he has the right to smoke, resident insist on going out and have been seen smoking outside alone without staff. On 3/22/2023 at 10:40AM, V1 (Administrator) said that she is aware that R4 was found with illegal drugs, she called the police, and the drugs were confiscated. The facility does not know how resident got the drugs, possible one of his friends that comes and pick him up. V1 said that using drug in the facility is a safety issue, some of the interventions the facility will implement includes increased monitoring for residents known to be using drugs, V1 added that residents with	S9999		

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S9999	Continued From page 5 substance abuse problem should have a care plan in place, the facility does not offer any group activities or therapy for drug use, residents are usually sent to the hospital for evaluation. A document presented by V1 (administrator) titled substance use disorder guideline, dated 10/24/2022 states in part that providing health care and supportive services is an integral part od person-centered environment. Staff should prepare to address emergencies related to substance use by providing increased monitoring...and contacting emergency medical services as soon as possible...Under interventions, the policy states among others, to develop and implement a person-centered care plan that include and support the care needs identified in comprehensive assessment, providing substance use treatment services such as behavioral health services, medication assisted treatment...and increased monitoring and supervision. R6 is a 31-year-old male with a history of Paraplegia, Opioid Dependence, Generalized Anxiety Disorder, Major Depressive Disorder, and Chronic Respiratory Failure who was admitted to the facility 03/03/23. R6's Admission Hospital report dated 03/02/23 documents he was admitted to the hospital. R6 has a history of opioid use disorder, withdrawal seizures, heroin dependence, polysubstance use including cocaine; hospital progress note for date of service 03/01/23 states poor prognosis, patient recently had rapid response due to unresponsiveness which responded to drug overdose medication, staff also found narcotic	S9999		

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pills next to patient; it appears patient is stacking up his narcotic pills; since non-compliance with medical therapy multiple medical problems; including polysubstance abuse patient is high risk for acute respiratory arrest; Hospital Psychologist progress note for date of service 03/01/23 states R6 expects discharge tomorrow, reported racing heart and anxiety possibly related to finding himself in a less restrictive environment and relatedly to managing that environment; Suggested he might ask for a psychologist at rehabilitation facility and perhaps attend video alcoholics anonymous meetings until he's able to attend in person; R6 has attended AA meetings in the past with fond memories of a caring sponsor and helpful group members; he has good social skills that will be put to the test as he faces various challenges ahead.

R6's most current care plan did not include substance use supervision or behavior monitoring.

On 03/21/23 from 11:58 AM - 12:07 PM V28 (Family Member) stated R6 was at another nursing home for 4-5 months and is a heroin addict. V28 stated R6 is paraplegic due to heroin use which affected his spinal cord. V28 stated the nursing facility R6 was previously in told him he couldn't visit R6 because he overdosed on heroin like 3-4 days before. V28 stated he had flown in to visit him at that nursing facility on approximately 02/08/23. V28 stated he was not allowed to visit R6, and R6 was not allowed to have visitors, or receive any outside deliveries because of his drug use and overdose. V28 stated once R6 arrived at the present facility he realized there was no supervision or restrictions and began texting heroin dealers then overdosed. V28 stated he wonders if it was included R6's

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medical records at the current nursing facility that he needed to be supervised. V28 stated a heroin dealer recorded himself stating he was posing as a food delivery driver and demonstrated how he would hide the heroin under R6's food and sent the video to R6. V28 stated R6 wanted confirmation of the heroin dealer being at nursing home and the dealer then sent another video confirming he was at the facility when he arrived. V28 stated R6 then transferred the money to the heroin dealer and the dealer delivered the food to the facility. V28 stated the nursing home staff collected the food bag and delivered it to R6.

On 03/21/23 at 12:23 PM V1 (Administrator) stated when food delivery drivers come to the facility they are directed to the nurses station and typically the nurse will deliver the resident's meal to them. V1 stated the only time staff checks food deliveries is to ensure the resident's delivered meal meets the consistency of their prescribed diets.

On 03/21/23 from 2:40 PM - 3:00 PM V5 (Social Services Director) stated he would become aware of a residents substance use history as a result of completing a social services questionnaire which is completed 48 - 72 hours after admission. V5 stated residents do not typically answer the questions about their substance use history honestly. V5 stated stated he would have to accept the answers they provide without having any knowledge of their history. V5 stated refusals of contraband searches are documented and the administrator would be informed. V5 stated he has observed residents in the facility under the influence of a substance. V5 stated social services staff along with the administrator would conduct searches. V5 stated both searches and refusals should be documented. V5 stated

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increased supervision would be initiated if this behavior continues. V5 stated there is no way to determine what visitors are bringing into the facility or to monitor what's being brought into the facility by residents.

On 03/21/23 at 3:05 PM V32 (Licensed Practical Nurse) stated when she left the facility on 03/03/23 between 10:30 PM - 11 PM R6 was in his room on his laptop with his headphones on watching a movie. V32 stated nurses or CNA's (Certified Nursing Assistants) will check food deliveries for residents for food consistency.

On 03/21/23 from 3:42 PM - 3:48 PM V33 (Certified Nursing Assistant) stated when she worked overnight from 03/03/23 - 03/04/23 she was R6's CNA. V33 stated R6 received a food delivery between 1-2 AM. V33 stated during this time the nurses were at their medication carts and she answered the door when a man came to the facility. V33 stated the man announced it was a delivery for R6 and handed her a paper bag with food from a fast-food restaurant. V33 stated the bag was prettylight and she did not open or look in the bag. V33 stated the man may have stated his name or stated he was from a food delivery service but she could not recall for sure. V33 stated she recalls coming in R6's room in the morning and finding the bag and food wrappers that he left behind crumpled up.

R6's progress note dated 3/4/2023 documents at 08:00 AM Nurse made morning rounds, walked in the room and spoke to residents, R6 appeared to be sleeping, Nurse touched the R6 and he moved, the roommate stated that "he just fell asleep." Nurse left the room and continued making rounds; at 08:30 AM nurse was notified by nurse that upon delivering meal trays that R6

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was unresponsive, nurse immediately went to assess R6, no pulse was present, no breathing pattern present. Vitals unable to articulate. CPR started and emergency medical services called; at 08:45 AM emergency medical services arrived and continued CPR; at 08:50 AM R6 was transported via emergency medical services to the hospital. On call physician and director of nursing were notified. Cause of death for R6 was undetermined at the time of this survey.

On 03/22/23 from 10:03 AM - 10:30 AM V1 (Administrator) stated if a resident has a history of substance abuse this information may be found in their referral information, or in their responses from the social services assessments. V1 stated sometimes family will provide this information. V1 stated a substance abuse history for R6 was a very big conversation prior to his admission. V1 stated the facility had V26 (Facility Liaison) speak with R6's mother at the hospital. V1 stated V27 (Family Member) was very present at the hospital because of his drug use and wanted to assure that people who were potentially influencing him were not coming to the hospital. V1 stated as a result the facility agreed that R6 could come to the facility as long as there was no drug abuse and were intending to have him complete a behavior contract as well as restricting any visitors per his mother's direction. V1 stated it seems that R6's mother knew exactly who he couldn't be around him. V1 stated R6's withdrawals had been gone for a while. V1 stated R6 had gotten drugs while in a hospital but is not sure which hospital this was. V1 stated this information was included in his referral paperwork. V1 stated the facility's concern was if he could get drugs at the hospital how can he be prevented from acquiring them at the facility which was the purpose of the conversation with

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R6's mother at the hospital (prior to admission). V1 stated when R6 was admitted she met with and greeted him on arrival and he showed no signs of being under the influence. V1 stated the facility's plan for managing R6's substance use was restricting visitors, monitoring his behaviors, and monitoring who came in and out of the facility. V1 stated the facility can't search residents without consent, and therefore if there is ever any concern or suspicion of substance use they would request a search. V1 stated if R6 needed psych services the facility would have referred him. V1 stated the facility also would have had the psychiatrist monitor medications. V1 stated social services would have also been seeing him. V1 stated the facility also conducts angel rounds. V1 stated those staff stop in and check on residents daily and if any issues are identified it will be reported during IDT (Interdisciplinary Team Meetings). V1 stated social services, R6's admitting nurse, and V3 (Director of Nursing) were made aware of R6's substance abuse history.

03/23/23 11:28 AM - 12:08 PM - V1 (Administrator) stated she is a nurse and if she was the floor nurse that's taking in a new admission, and that resident comes to the facility with an order for a general diet, and does not have an order for feeding assistance she would not be prompted to monitor them during meals. V1 stated that the admitting nurse has to follow orders.V1 stated when a hospital sends orders for medications and diet they are informing that the current orders are what is normal for the patient. V1 stated R6's hospital report is documenting his medical history and not his current status especially with regards to suctioning and trach use. V1 stated R6's Hospital record was received on admission and not reviewed preadmission. V1

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S9999	Continued From page 11 stated R6's complete admission hospital paperwork would have been reviewed and his care plan implemented based on all his admission assessments within 24 hours of admission. V1 stated based on R6's original referral packet that was received, the facility was able to care for R6. V1 stated based on R6's complete admission hospital paperwork, the facility would have been able to monitor and care for him with his medical and substance abuse history. V1 stated the facility becomes aware of how resident's with a history of substance abuse acquire substances through their social history and if they're honest in providing this information. V1 stated the facility can always conduct a drug screen, however this would be based on suspicion of current substance use. V1 stated the facility does not consult with anyone on ways in which individuals with a substance abuse history acquire substances. V1 stated the facility does not have substance abuse specialty staff. V1 stated the facility has to rely on information resident's provide about substance use habits and they are not always honest. V1 stated besides the resident providing this information, the facility would rely on observations of changes in behavior, physical, and mental status to determine a residents substance use habits. (B) 2/2 300.610a) 300.1210b) 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	S9999		

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S9999	Continued From page 12 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. Section 300.1210 General Requirements for Nursing and Personal Care 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. The facility failed to have effective, resident-centered, fall interventions in place for residents that are known to be high risk for falls to prevent residents from having repeated falls in	S9999		

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the facility. These failures applied to five (R3, R12, and R15) of five residents reviewed for accidents and supervision and resulted in R3, R12 and R15 did not have effective and resident-centered fall interventions in place to prevent the residents from having multiple falls while in the facility, and resulted in R3 having a fall that required transfer to hospital and 14 stitches above the left eyebrow.

R12 is a 71-year-old male with a diagnoses history of Abnormalities of Gait and Mobility, Unsteadiness on Feet, Contracture of Muscle of Lower Leg, Neutropenia due to Infection, Dementia, Parkinson's Disease, Protein Calorie Malnutrition, and History of Falling who was admitted to the facility 12/14/21.

R12's most recent Fall Risk Assessment dated 06/06/22 documents a fall risk score of 8 indicating not at risk for falls with fall risks including 1-2 falls in past 3 months, 1-2 high risk medications, and 1-2 predisposing diseases.

R12 does not have any other fall risk assessments after June 2022 in his medical record.

R12's Current care plan documents he is at moderate risk for falls related to poor balance and decreased mobility with interventions including: Anticipate and meet The resident's needs; Put Sign " call for help before you get up".

The Facility's Fall Log from 12/21/22 - 03/21/23 documents R12 had an unwitnessed fall 01/07/23.

R12's Incident report dated 01/07/2023 6:00 AM documents R12 had an unwitnessed fall in his

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S9999	Continued From page 14 room. R12 reported he was trying to get up and walk and fell to the floor. R15 is an 80-year-old male with a diagnoses history of Dementia with Behavioral Disturbance, History of Falling (effective 02/18/2022), Spondylosis, and Delirium due to Physiological Condition who was admitted to the facility 02/18/2022. On 03/21/23 from 10:32 AM - 10:47 AM Observed R15 standing on the floor mat next to his bed holding and walking around the bed while holding onto the foot board. Observed R15's upper body and arms to be wobbling while attempting to hold on to foot board and walk. Observed no staff present in or near R15's room during this time. On 03/21/23 from 10:47 AM - 10:50 AM Observed V13 (Certified Nursing Assistant) go into R15's room to find him attempting to walk. Observed V13 ask R15 what he was doing and explain she'll assist him. Observed V13 leave R15's room. Observed R15 walk out into the hall with an unsteady balance. Observed V13 assist R15 with walking back into his room explain she'll assist him after getting his roommate up and out of bed. Observed V13 leave R15's room. R15's Current Care Plan documents he is at risk for falls related to poor safety awareness, altered balance, and history of falling with interventions including: Anticipate and meet The resident's needs; Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed; The resident needs prompt response to all requests for assistance; Educated resident on self-transferring or sitting on floor educated asking for assistance	S9999		

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demonstrated call light with return demonstration; Bilateral floor matt; Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as unsteady gait; Ensure that The resident is wearing appropriate shoes, when ambulating or mobilizing in wheelchair; Falling leaf program; Resident preferring to sit on the ground. (initiated 08/30/22) Lab review 12/21/22 fall; redirecting resident to use the walker to walk (Date Initiated: 01/10/2023); Occupational Therapy will eval and treat 2/2/23; Patient evaluate and treat as ordered (initiated 02/18/22) Follow facility fall protocol; lab order and urinalysis related to March fall.

The facility's fall Log from 12/21/22 - 03/21/23 documents R15 had unwitnessed falls 12/21/22, 12/30/22, 01/09/23, 02/02/23, 03/03/23.

R15's Incident report dated 12/21/22 9:00 PM documents he had an unwitnessed fall in the hallway and was observed in the hallway on floor laying in a left side lying position with head up against the wall. Educated on call light use; Predisposing environmental factors included safety interventions already in place; Predisposing psychological factors include recent illness and other.

R15's progress note dated 12/30/2022 11:00 PM documents Resident had an un-witnessed fall 12/30/2022 11:00 PM Location of Fall: resident room; upon making rounds the writer and cna observed residents in his room, on the floor beside his bed, lying supine with head against bed frame, resident speaking gibberish language, writer completed full body; 11:30 PM Note documents upon making rounds the writer and Certified Nursing Assistant observed resident in

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S9999	Continued From page 16 his room, on the floor beside his bed, lying supine with head against bed frame, resident speaking gibberish language, writer and CNA assisted resident back to bed physician was made aware, order to send resident out to hospital, all parties notified and made aware. R15's medical records did not include an incident report for his fall 12/30/22. R15's Incident report dated 01/09/23 2:00 AM documents he had an unwitnessed fall. R15 was observed in the hallway on his knees and reported he was trying to walk then he fell. Predisposing physiological factors include confusion, gait imbalance, decline in cognitive skills; Predisposing situation factors include behavior symptoms, wanderer. R15's Incident report dated 02/02/23 9:04 PM documents he had an unwitnessed fall. R15 was observed in hallway laying on the floor and reported he fell. R15 was educated on using walker when ambulating or walking through the hallway. Predisposing environmental factors include safety interventions already in place; Predisposing situation factors include ambulating without assist. R15'a fall risk assessment dated 12/21/22 documents a risk score of 10 with risk factors including intermittent confusion, 1-2 falls in the past 3 months, ambulatory/incontinent. R15's Fall risk assessment dated 02/02/23 documents a risk score of 10 with risk factors including intermittent confusion, 1-2 falls in the past 3 months, ambulatory/incontinent, and balance problem while standing and walking. This fall risk assessment does not document his	S9999		

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S9999	Continued From page 17 current fall status of 3 or more falls in the past 3 months and multiple contributing conditions as reported in medical history. R15's Occupational Therapy Evaluation dated 02/08/23 documents diagnoses include Dementia with Behavioral Disturbance, (effective 10/19/22), Delirium due to Physiological Condition (effective 10/19/22), Lack of Coordination (effective 02/07/23), Abnormal Posture (effective 02/07/23), and Weakness (effective 02/07/23); reason for referral includes history of left hip replacement and frequent falls, decrease in strength, reduced balance, reduced transfer safety, and increased need for help from others; medical factors include anxiety, confusion, and can be agitative. R15's Therapy to Nursing Recommendations dated 02/08/23 documents patient displays poor safety awareness and poor carryover. Patient requires close supervision for all tasks. R15's Incident report dated 03/03/23 10:48 PM documents he had an unwitnessed fall. R15 was found in his room sitting on the floor by his roommates bed and was noted with a small skin tear to the left arm/elbow area. Predisposing physiological factors include confusion, impaired memory; Predisposing situation factors include wandering. R15 does not have a fall risk assessment for his fall occurring 03/03/23. On 03/22/23 from 10:03 AM - 10:30 AM V1 (Administrator) stated V1 stated the fall coordinator for the past 6 months has been V3 (Director of Nursing). V1 stated the Director of Nursing is the person mainly responsible for collecting all fall related information gathered	S9999		

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S9999	Continued From page 18 during IDT (Interdisciplinary Team) meetings, QA (Quality Assurance) meetings, from incident reporting and investigating, and then preparing reports based on that information. On 03/22/23 from 1:25 PM - 1:50PM V3 (Director of Nursing) stated R15 has had multiple falls due to dementia and increased weakness. V3 stated she is not sure if labs or medication reviews have been done for R15. V3 stated R15 ambulates freely and his balance is sometimes good and sometimes not. V3 stated R15 was evaluated by therapy staff but is not sure when and will find out. V3 stated R15 should have a diagnosis of weakness. V3 stated the physician diagnoses weakness based on nursing reports and their on assessment. V3 stated fall risk assessments are completed on admission and when an incident occurs. V3 stated R15 is impulsive and confused and is alert and oriented to person only. V3 stated R15 has a walker and is non-compliant with it. V3 stated R15's falls are usually not in his room. V3 stated R15 needs increased supervision. V3 stated ideal supervision for R15 would include being monitored by staff. V3 stated there are staff in the dining room. V3 nurses checking up on R15 as well would be beneficial. V3 stated possibly having R15 closer to the nurses station would be beneficial but this would not necessarily help because he falls anywhere. V3 stated staff at the nurses station would see R15 when he comes out of his room, but he walks all around the building. V3 stated staff are on the floor constantly. V3 stated most of the time the staff are in the open area such as the dining room and CNA's (Certified Nursing Assistants) are typically in the rooms providing care. V3 stated staff would see R15 when conducting rounds. V3 could not explain why R15 had so many unwitnessed falls. V3 stated the risks from continued falling includes	S9999		

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S9999	Continued From page 19 bleed out, fractures, and severe injuries. V3 stated the facility's policy is to prevent falls. V3 stated therapy may help R15's increased weakness and is not sure if he's currently in therapy. V3 stated fall risk assessments should be completed accurately in order to determine fall risks appropriately. V3 stated the fall risks assessments should comprehensively capture the resident's fall risks. The facility's Fall Prevention Program Policy reviewed 03/23/23 states: "Purpose: To ensure the safety of all residents in the facility when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of flals and implementations of appropriate interventions to provide necessary supervision as necessary." "The fall Prevention Program Includes: Methods to identify risk factors, Assessment time frames, Use and implementation of professional standards of practice; Care Plan incorporates: Identification of all risk/issue, Preventative measures, Interventions are changed with each fall as appropriate." "A fall risk assessment will be performed at the time of admission." "A fall risk assessment will be performed at least quarterly and after any fall incident." "Accident/Incident reports involving falls will be reviewed by the interdisciplinary team to ensure appropriate care and services were provided and determine possible safety interventions." "The frequency of safety monitoring will be determined by the resident's risk factors and the plan of care." "In the event safety monitoring is initiated for 15-30 minute periods, a documentation record will be used to validate observations."	S9999		

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R3 is a 92-year-old, male, admitted in the facility on 12/06/21 with diagnoses of Cerebral Infarction, Unspecified; Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side and Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood disturbance and Anxiety. According to MDS (Minimum Data Set) dated 01/16/23 under Section C, R3's BIMS (Brief Interview for Mental Status) score was 6, which means severe cognitive impairment.

Fall risk assessment dated 10/02/22 documented that R3 is at risk for falls.

Incident report dated 11/07/22 recorded that R3 fell from his wheelchair and was observed on the floor by the nurses' station. It was revealed that he (R3) was propelling himself around the nurses' station when he looked down and leaned forward, which he normally does causing him to slid and fell from his wheelchair. R3 sustained an open area to the left side of his forehead above the eyebrow. Minimal bleeding was noted and first aid was rendered. He was sent to the hospital as ordered. He came back to the facility with 14 stitches above the left eyebrow.

R3's progress notes documented in part but not limited to the following:
11/07/22: Had an unwitnessed fall; 11/07/22 at 2:30 PM, hallway - stated he slipped out of his wheelchair and fell on his left side, sustained laceration to his left eyebrow, sent to emergency room.
11/08/22: arrived in facility at 9:30 PM with wound

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S9999	Continued From page 21 covered; with stitches - 14 stitches noted above resident's left eyebrow. On 03/20/23 at 12:32 PM, R3 was in his room, sitting in bed. He suddenly stood up reaching for the bedside table as he tried moving it closer to him. V6 (Licensed Practical Nurse, LPN) saw R3 from the hallway as she passed by to go to another resident's room. V6 assisted him back to bed and placed the bedside table close to him. On 03/21/23 at 12:05 PM, R3 was observed in the dining area, in his wheelchair, waiting for lunch to be served. All of a sudden, he moved his wheelchair using his legs wanting to leave but was redirected. On 03/22/23 at 12:45 PM, V15 (Certified Nurse Assistant, CNA) was asked regarding R3's fall incident on 11/07/22. V15 stated, "I was assigned to him. I was still here but I don't remember what happened to him. When he is out of his room, we put him in the dining room but he moves around. He goes everywhere. We all watch him, if he goes to other direction, we redirect him. He will always say that he was just exercising his legs. He uses his legs and feet to move the wheelchair. To prevent him from falling, since he cannot stay in one place, we watch and monitor him closely because he still thinks that he can do things by himself." V24 (LPN) was also asked regarding R3 on 03/22/23 at 2:09 PM. V24 replied, "On 11/07/22, I was working. I don't know how his fall occurred. He was seen on the floor. It was at the hallway by the nurses' station. He was at the sitting area across the big dining/activity area. Staff were doing their work at the time. I am not sure the exact time of the fall. It was afternoon shift. He	S9999		

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S9999	Continued From page 22 (R3) stated that he slipped out of his wheelchair. I was not at the nurses' station. I was called and was told that he was on the floor. He sustained a laceration on the left eyebrow, and he was sent out to the hospital. He walks with his wheelchair. We make sure that he doesn't fall especially when he is in the dining area. He moves around. It is hard to supervise him since we don't follow him and do a one on one supervision. What we can do is we monitor him closely." V3 (Director of Nursing) was interviewed on 03/21/23 at 3:09 PM regarding R3. V3 stated (B)	S9999		