STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006191	A. BUILDING: _____ B. WING _____	C 06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE NILES	8333 WEST GOLF ROAD NILES, IL 60714

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S 000	Initial Comments Complaint Survey: 2394080/IL159935, 2393471/IL159157, 2393864/IL159662, 2394098/IL159984,2393008/IL158599	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 1. 300.610a) 300.1210b) 300.12010d)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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 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 observation, interview, and record review the facility failed to follow their wound prevention policies and plan of care interventions to include use of low air loss mattress and conduct skin condition assessments and measurements weekly. This affected 2 of 3 residents (R6, R8) reviewed for pressure sore prevention. This failure resulted in R6 having a deteriorating wound requiring debridement revealing a stage 4 pressure sore. Findings include:	S9999		

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S9999	Continued From page 2 1. R6 face sheet shows diagnosis of hemiplegia and hemiparesis following cerebrovascular disease, vascular dementia without behavioral disturbance, hypertensive heart and chronic kidney disease, chronic systolic heart failure, atherosclerotic heart disease, encounter for attention to gastrostomy, chronic embolism and thrombosis of right femoral vein, chronic embolism and thrombosis of left popliteal vein, long tern use of anticoagulants, abdominal distension, alcohol abuse, blindness of right eye, latent tuberculosis, and dysphagia. R6 braden score (risk for skin breakdown) dated 5/31/2023 denotes score of 10 (high risk) for skin breakdown. R6 progress notes denotes R6 was sent to hospital on 5/12/23 and returned to facility on 5/17/23. On 6/6/23 at 12:00pm R6 was observed sleeping in bed, R6 open his eye to voice, R6 did not follow redirection at this time. R6 resting on mattress with no pump noted at foot of bed or head of bed or on the floor near the bed. R6 has gastric tube feeding running at 45ml/hr., water flush at 130ml every 4 hours. Tube feeding labeled and dated. R6 has bilateral heel boots. R6 observed with bilateral hand mitten. R6 hair is cut low, facial hair observed trimmed. No body odor noted, no mouth odors noted. R6 observed resting on mattress, no mattress pumps noted. . At 12:17pm wound care and skin check observation conducted with V8 (wound care nurse) and V9 (wound care coordinator). R6 skin was intact to heels bilaterally, skin intact to peri area, skin intact to elbows, skin intact to back, skin intact to back of head, skin intact to ear lobes. R6 has wound the size of a grapefruit to	S9999		

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the right buttocks that extends to the sacrum; wound has black tissue with tan tissue were the wound is open partially. R6 has open area to the left buttocks the size of a half dollar; wound bed is pink, moist, surrounding tissue is hyperpigmented. V8 said the wound to the right buttock has tunnelling, V8 said the wound doctor is planning to debride the wound when it opens. V8 said the wound has open edges now and he will notify the wound physician for an update. V9 said R6 was admitted to the facility with the wound. Pain medication given prior to wound care observation. After wound care R6 repositioned for comfort. V9 said R6 mattress is a low air loss mattress, when asked where's the pump for the low air loss mattress, V9 then said R6 was resting on a pressure redistributing mattress, the facility regular mattress are pressure redistributing. R6 mattress was firm when pressed. V9 said the wound doctor usually see residents on Tuesday, however the wound doctor had an emergency, and he would see residents on Wednesday. V9 said R6 should have in place a low air loss mattress. On 6/14/23 V9 said the mattress should have been in place upon readmission on 5/17/23 or 5/18/23.

R6 plan of care dated 9/14/2022 denotes in-part R6 has high risk for further skin breakdown related to decreased mobility, incontinence, O2 (oxygen) dependent, Dx (diagnosis) hemiplegia, heart failure, vascular, dementia, and blindness to right eye and refusal of care, 1- coccyx initiated 9/14/22, R6 wound site will show signs of improvement through next review date, initiated 5/18/2023. Apply moisture barrier after each incontinent episode, evaluate ulcer characteristics, keep skin clean and well lubricated, low air loss mattress 9/14/22, low air loss mattress 10/25/22, monitor bony

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prominences for redness, monitor nutritional status, monitor ulcer for signs of progressions or declination, off load heels while in bed, provide skin care per facility guidelines and PRN as needed, provide wound care per treatment order, RD (register dietitian) consults, turn and reposition every 2 hours and as needed, wound Dr/ Np consults as needed.

R6 wound assessment dated 5/18/23 denotes in-part wound-coccyx, pressure ulcer, present on admission, size- 4.50 centimeters by 3.00 centimeters, unknown depth, area 13.50 centimeters squared. R6 wound assessment dated 5/24/23 denotes in-part wound-coccyx, pressure ulcer, present on admission, size- 4.50 centimeters by 3.00 centimeters, unknown depth, area 13.50 centimeters squared.

R6 wound assessment completed by V38 (wound doctor) dated 5/30/23 denotes in-part patient seen on the request of the PCP (primary care provider) for skin ulcers/lesions. Skin problem site- coccyx, wound #4 coccyx un-staged, there is no exudate, infection or inflammation is none, the wound is 12 days since first recorded. Assessment and plan abnormal posture- monitor skin PROM, muscle weakness-low air loss mattress, reposition every 2 hrs (hours) and PRN, offload heels, heel protectors to both feet. Pressure ulcer sacral region, unstageable, frequency of treatment- daily and PRN, site should be cleaned with with normal saline, primary dressing-Medi honey, adaptic, ZN (zinc) oxide around, secondary dressing - foam island dressing, secure with off load, additional notes- please call me when the edges open so that I can debride and get the consent for debridement. Plan of care #5 continue with skin ulcer prevention protocol of the facility including daily

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skin check. #7 dressing change and plan discussed with treatment nurse. Avoid bony prominences under pressure, provide stage appropriate mattress, off load with heel protectors or pillows, repositioning in the bed and w/chair as needed, or per facility protocol, if patient cannot do it, education of staff and nurse assistant about prevention and treatment and repositioning as needed. Comments seen with WCC (wound care coordinator) (V8). Page 4 wound #4, coccyx, un-staged, pressure, date reported 5/18/23, size 8x11x0, 100% necrotic, undefined margins, treatment done 5/30/23.

R6 wound assessment completed by V38 (wound doctor) dated 6/9/23 denotes in-part patient seen on the request of the PCP (primary care provider) for skin ulcers/lesions. Removal of necrotic tissue, slough, and biofilm and reduced bioburden, to promote healing and prevent infection. Tissue debrided was necrotic subcutaneous, necrotic muscle, percentage area was debrided 51-75%, viable wound bed was exposed. Page 5 denotes MDS stage 4, pressure, post debridement size- 9x11x2.5. Post debridement volume 247.5 centimeters squared. Necrotic/ escar color 90%, intact 10%. Treatment done 6/9/23, topical application gentamicin, calcium alginate, ZN(zinc) . Treatment has been changed.

On 6/9/23 at 12:37pm V38 (wound physician) said R6 was re-admitted to the facility with the wound on 5/17/23, V38 said R6 wound has deteriorated, V38 said R6 has deep tissue injury. V38 said when there's deep tissue injury it takes about 72 hours or 4 days for the injury to present on the skin (show up). V38 describe deep tissue injury happens when pressure from bony prominences cause tissue to die due to lack of

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S9999	Continued From page 6 oxygen. V38 said it takes about 4 days for the injury to show on the skin because the injury happens deep inside. R6 admission dates were reviewed with V38 of 5/17/23, when 4 days is added to 5/17/23 the date is now 5/21/23, R6 wound assessment and images dated 5/24/23 reviewed with V38, R6 wound to "coccyx" measured the same as the 5/18/23. V38 was asked should the deep tissue injury should have come to the surface by then. V38 said R6 had a deep tissue injury. V38 said R6 deteriorated wound was debrided today to reveal a stage 4 pressure ulcer. V38 said wound debriding removes the necrotic tissue. V38 said the low air loss mattress assist pressure prevention. V38 was made aware that during the observation on 6/6/23 at 12:37pm R6 did not have the low air loss mattress in place, V38 said "oh no that not good". V38 said not having that low air loss mattress in place can contribute to R6 wound deteriorating. V38 said cultures were sent today and R6 wound treatment was changed from honey to gentamicin. V38 said R6 previous wound healed. Facility policy tilted pressure injury and skin condition assessment with last review date 1/17/2018 denotes in-part to establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure injuries and other ulcers and assuring interventions are implemented. The resident care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches, and goals for care. Physician ordered treatments shall be initiated by staff on the electronic treatment administration record after each administration. Other nursing measure not involving medications shall be documented in weekly wound assessment or nurse noted.	S9999		

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S9999	Continued From page 7 Facility policy titled pressure ulcer prevention with last revision date 1/15/2018 denotes in-part to prevent and treat pressure sores/pressure injury. Pressure reducing (foam) mattress are used for all residents unless otherwise indicated. Specialty mattress such as low air loss, alternating pressure, etc. may be used as determined clinically appropriate. Specialty mattress are typically used for residents who have multiple stage 2 wounds or one or more stage 3 or stage 4 wounds. Facility policy titled comprehensive care plan dated 11/17/17 denotes in-part to develop a comprehensive care plan that directs the care team and incorporates the resident's goal, preferences, and services that are to be furnished to attain or maintain the residents highest practicable physical, mental psychosocial well-being. The facility will develop and implement a comprehensive person centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical nursing and mental and psychosocial needs that are identified in the comprehensive assessment. 2.R8 care plan denotes R8 has diagnosis of chronic respiratory failure, obesity, DVT, glaucoma, long term use of anticoagulants, pressure ulcer left elbow, anemia, chronic kidney disease, atherosclerotic heart disease, acute embolism, long term use of insulin, protein calorie deficits. R8 Braden assessments dated 4/27/23 denotes score of 9 (very high risk). On 6/7/23 at 11:30am R8 observed for wound	S9999		

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S9999	Continued From page 8 care with V9 (wound care coordinator) and V8 (wound care nurse), V9 (wound care coordinator), R8 left elbow noted with granulated tissue covering the wound bed, V9 said R8 only had preventive measures in place for the right elbow. On 6/8/23 V9 presents R8 wound documents denoting R8 has pressure wound to the right elbow, and R8 MAR denotes preventive dressing to the right elbow. On 6/9/23 at 9:50am skin check/wound care observation conducted with V8 (wound nurse), R8 noted with open area to the right elbow, wound bed observed moist and redden, with little yellow tissue inside wound bed. V8 said R8 has a stage 3 to the right elbow. V8 said R8 right elbow wound is facility acquired. On 6/9/23 at 1:50pm V9 (wound care coordinator) said she was not aware that R8 had an open wound to the right elbow. Review of R8 wound assessment completed by V35 (wound physician) on 5/23/23 denotes in-part right elbow, un-staged, pressure date reported 3/24/23, size- length (2 centimeters) by width (2 centimeters) by depth (0.2 centimeters). Post debridement measurements (2 centimeters) in length by (2 centimeters) in width by 0.4 centimeters in (depth). 60% granulation, 10% necrotic, and 30% slough. Pressure ulcer of right elbow, frequency of treatment- daily and PRN (as needed), site should be cleaned with normal saline, primary dressing- iodosorb adapatic, secondary dressing-4x4, secure with loose kerlix, wound debrided 5/23/2023. Plan of care #5 continue with skin ulcer prevention protocol of the facility including daily skin check. #7 dressing change and plan discussed with treatment nurse. Comments seen with WCC (wound care coordinator) V9 and wound nurse (V8). Facility wound report presented by V9 on 6/9/23	S9999		

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S9999	Continued From page 9 dated 6/9/23 denotes in-part R8, right elbow, date identified 6/9/2023, facility acquired (yes), pressure/ulceration, last assessed 6/9/23, stage 4, Length 2.50, width 2.50, depth 2.00, epithelia (pale pink or red) 100%, erythema, scant exudate, serosanguineous. Facility failed to present weekly skin assessments following the week of 5/23/23 for R8 during this survey. On 6/9/23 at 3:15pm V8 said weekly wound assessments include measurements, descriptions, including restaging the wounds by the physician. V8 said wound changes would be documents weekly or as needed, V8 said wound changes are necrotic tissue, slough, infection, change wound bed, and if the wound is purple, pale, if there's concerns for flow to the wounds, V8 said all residents admitted to facility with wounds will be seen by the wound doctor regardless of the stage of the wound. V8 said this allows for them to contact the wound doctor when there is a change int the wound. V8 said the wound doctor sees all residents with sacral wounds, stage 3 and stage 4 wound weekly. V8 said he can stage wounds and the wound physician will follow up with staging the wound. Facility policy titled pressure injury and skin condition assessment with revision date of 1/17/18 denotes in-part the purpose to establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure injuries and other ulcers and assuring interventions are implemented. Pressure and other ulcers (diabetic, atrial, venous) will be assessed and measured at least every seven (7) days by licensed, and document in the resident's clinical record. A skin condition assessment and	S9999		

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pressure ulcer risk assessment (Braden) will be completed at the time of admission/readmission. The pressure ulcer risk assessment will be updated quarterly and as necessary. Resident identified will have a weekly skin assessment by licensed nurse. A wound assessment will be initiated and documented in the resident's chart when pressure and/or other ulcers are identified by licensed. A disposable measuring device (one time use) will be used to measure dimensions, and if necessary, a clean cotton tipped applicator to measure wound depth/ tunneling/ undermining. Pressure injuries and other ulcer (arterial, diabetic, venous) will be measured at least weekly and recorded in centimeters in the resident's clinical record. A wound assessment for each open area will be completed and will include: site location, size(length x width x depth), stage of pressure ulcer, odor, drainage, description, date and initials od each individual performing the measurements.

(B)

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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

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S9999	Continued From page 11 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. 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 observations, interviews, records reviewed the facility failed to develop and implement individualized and effective fall prevention interventions to prevent or reduce the incidents of falls with injury. This affected 2 of 3 residents reviewed for falls with injury. This failure resulted in R2 having an unwitnessed fall being transported to hospital with a change in condition post fall. R2 was admitted to the hospital for abnormal with a complex left cerebral subdural	S9999		

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hematoma containing significant acute hemorrhage. R2 expired 14 days related to complication of the fall. This failure also resulted in R1 having an unwitnessed fall sustaining a comminuted right femoral intertrochanter fracture

Findings include:

1.R2 was 84 years old with diagnosis including but not limited to Fibromyalgia, History of Falling (Onset 12/17/2021), and Weakness. Cognitive patterns dated 3/8/23 documents he has modified independence for daily decision making.
On 6/7/23 at 11:54AM V22, Restorative Nurse, said the purpose of the CNA charting is to know how many people assist the residents and for the staff to know how much assistance the patient needs. V22 said CNAs are told to document every shift and every time they assist the residents. V22 said blanks in the charting means it (the care) did not happen. V22 said the residents should have bed mobility charted on all shifts. V22 said if the charting is not documented then it did not happen. V22 said a fall is a change in plane. V22 said unless I saw them fall then it is a fall. V22 said she updates the care plan after a fall but she does not document the root cause. V22 said the purpose of the root cause analysis is to know what caused the fall.

On 6/7/23 at 1:32PM V18, Registered Nurse, said R2 usually did not try to get out of the bed. V18 said standard care included to round frequently and offer R2 help. V18 said R2 had a call light but I am not sure if he would use it. On 3/8/23 (morning) R2 was having normal behavior, he was non-verbal. V18 said R2 would sit up in the bed in the middle of the bed with his legs out. V18 said on 3/8/23 9:00AM when I was rounding I saw him on the floor by his bed. V18 said I had seen

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S9999	Continued From page 13 R2 prior to the fall, R2 was sleeping. V18 said when I walked in the room R2 was laying on the floor on the mat. V18 said R2 was flat on his back. V18 said R2 could not stand but was able to pull himself up into a sitting position. V18 said I did not ask R2 what he was trying to do. V18 said I did not see him fall and the roommates said they did not see anything. The surveyor asked V18, did R2 hit his head and V18 said I don't know if he hit his head V18 said it is possible for the patient to have an injury without signs of injury. V18 said there was a night stand next to the bed on the side R2 fell. V18 said usual rounding is every 2 hours. V18 said I was checking R2 every 30 minutes. V18 said I reported to the oncoming nurse that R2 had a fall and had no signs of pain and the nurse practitioner saw him. V18 said when a resident falls we do a head to toe assessment and make sure there is no injury. V18 said we make sure they did not hit their head. On 6/7/23 at 1:53PM V10, Assistant Director of Nursing, said when a resident falls "immediately the nurse develops a new intervention". V10 said the nurse communicates the intervention verbally to the next shift and then adds the new intervention to the careplan. During a phone interview on 6/8/23 at 11:08AM V28, Nurse, said on the evening shift 3/8/23 R2 fell and he was more anxious so she reported it to the doctor. V28 said R2's baseline is alert, but he can't talk or have conversations and can't communicate his needs. V28 said I don't know how R2 got on the floor on 3/8 (evening). V28 said at the start of her shift she was told R2 had a fall earlier. V28 said the intervention was to do more frequent rounding and keep an eye on him. V28 said we tried to check on R2 to make sure	S9999		

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S9999	Continued From page 14 he was ok. V28 said she was notified R2 was on the floor by V34, Certified Nursing Assistant (CNA). V28 said on 3/8/23 she last saw R2 around dinner time, 5:00PM and could not recall if she saw R2 prior to the fall. On 6/9/23 at 10:19AM V13, Director of Nursing (DON), said V22 is the fall coordinator and she follows the falls in the building. V13 said V22 makes sure the interventions are in place. After V13 reviewed R2's incident report with the surveyor, V13 said on 3/8/23 at 9:00AM R2 was attempting to reach items from the floor. R2 said the intervention following R2's fall was to provide a reacher. V13 said when she interviews the staff following a fall she does not document it and she only documents the interviews if the incident is a reportable that goes to IDPH. V13 said the nurse's statement will be documented in the nurse's notes. The surveyor asked if the reacher was provided to R2 and V13 said I need to check with V22 if the reacher was provided. V13 said as a whole, R2 is difficult to redirect, very impulsive, and he does not ask for assistance. V13 said due to R2's cognitive status he is difficult to educate even with the use of an interpreter. The surveyor asked V13 how R2 was going to retain the information to use a reacher? V13 said R2 could do a return demonstration. V13 said R2 was told if you need assistance please call, but that was difficult for him to retain. V13 said there could have been more effective prevention interventions for R2. V13 said each resident fall should be addressed in the care plan or the care plan updated. V13 said I expect the interventions on the care plan to be carried out. At 11:26AM V13 said we did not do a monitoring sheet for R2 after his fall on 3/8/23 at 9:00AM, we did not do that intervention.	S9999		

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S9999	Continued From page 15 On 6/9/23 at 2:58PM V22 said I don't know why there is a sign on R10's room (R2's former room mate) to keep the door closed. V22 said a person who has had previous falls should not have the room door closed. V22 said she discussed implementing the reacher with the staff but she did not physically provide it to R2. On 6/9/23 at 3:02PM V13 and V22 were asked together who is the fall coordinator for the facility. V12 said V22 is. V22 adamantly said "I am not the fall coordinator." On a follow up in person interview on 6/9/23 at 3:28PM V28 said I could not tell if R2 hit his head, V28 said she was informed of R2's fall by the CNA who said the call light was on. V28 said I don't recall if the door to R2's room was closed. V28 said R2 does not usually wear shoes and I can't recall if he had socks on. V28 said I was not told anything about a reacher device to be used for R2. V28 said when she saw R2 he was on the floor, next to his bed, on a mattress and his head was near the footboard of his bed. V28 said I called the ambulance right away. On 6/9/23 at 3:15PM during in person interview V34, CNA, said I can't remember about R2's fall. V34 was unable to answer any of the surveyor's questions regarding R2 or his shift on 3/8/23. V34 said he remembers entering R2's room because the call light was on and then saw R2 on the floor mattress but that was all he could remember. On 6/9/23 at 2:49PM The surveyor asked V39, LPN, about the sign on R10's door that reads keep door closed at all times. V39 said let me ask about the sign on the door and V39 approached R10. R10 (speaking in Korean to V39) said he does not recall his former room mates or anything	S9999		

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else. R10 said he requested his door be kept closed since last fall because he feels a chill from the hall way. R10 told V39 who told the surveyor R10 requested the sign be put up on his door sometime last fall. R10 told V39 who told the surveyor the sign was put on his door by the Korean Manager. (Based on the interview is reasonable to conclude the door was closed when R2 fell.)

On 6/14/23 at 11:53PM V40, Nurse Practitioner, said R2 was a fall risk because he as Dementia and he was not able to comprehend his safety needs. V40 said all fall precautions that could have been initiated, were initiated. V40 said I don't believe R2 could retain any information given to him by staff. V40 said the purpose of fall precautions is to prevent falls. V40 said "if a patient's condition worsens, I expect the staff will check on the patient frequently". V40 said patients who are acute should be checked on more frequently. V40 said a significant hit on the head can cause a subdural hematoma.
Incident Reports document R2 had a fall on 1/11/23 a fall on 3/8/23 at 9:00AM and a fall on 3/8/23 at 9:35PM. Behavior assessment dated 3/8/23 documents no behaviors related to psychosis, physical or verbal symptoms, or behaviors directed towards others. R2 had rejected care during 1-3 days of the assessment.

R2's Functional Status assessment dated 3/8/23 documents he requires extensive assistance with bed mobility and transfers between surfaces.

R2's Incident Report dated 1/11/23 documents R2 was sitting next to bed. Notes sections denotes encouraged R2 to ask for assistance and staff reminded to anticipate needs.

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S9999	Continued From page 17 R2's Incident Report dated 3/8/23 9:00AM documents observed on the floor next to his bed. Root cause dated 3/15/23 notes R2 with history of falls, very impulsive, difficult to redirect. Attempting to reach items on floor/nightstand etc. R2's Incident Report dated 3/8/23 9:35PM documents R2 had unwitnessed fall. Observed at the side of the bed. In supine position with head on the footboard side of the bed. R2's Behavioral Symptoms Code denotes 0 behaviors on 3/7/23 - 3/8/23. R2's Documentation Survey Report dated 3/8/23 has no entry for day or evening shift. This includes Bed Mobility and Dressing. R2's Fall Scale Evaluation dated 1/11/23 notes R2 has a fall risk scale of 55. Scoring indicates high risk is a score of 45 and higher. Mental Status notes R2 overestimates or forgets limits. Careplan initiated on 12/20/21 documents R2 is a at risk for falls related to impaired cognition, limited mobility, weakness, incontinence, poor safety awareness, and history of fall. Intervention dated 1/11/23 denotes: staff to anticipate resident's needs. Encouraged to ask for assistance. Intervention dated 3/8/23 keep needed items water, etc. in reach. Assess ability to use and provide reacher. Intervention initiated on 12/20/21 denotes past falls and attempt to determine cause of falls. Record possible root cause. Careplan focus dated 12/23/21 denotes R2 has a right hip fracture related to a fall. R2's progress notes written by Nurse Practitioner	S9999		

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S9999	Continued From page 18 dated 3/6/23 document fall precautions. R2's progress notes dated 3/8/23 at 10:53AM R2 had a recent fall. Progress notes at 11:12am written by nurse practitioner document status post fall follow up. Fall precautions to be maintained. On 3/8/23 at 9:52pm R2 had a fall. R2's progress notes dated 3/9/23 3:06PM document R2 admitted for subdural hematoma. At 3:19AM R2 being admitted to the hospital with diagnosis of fall. R2's record including a head CT denotes result time 3/9/23 at 2:02AM examination is abnormal with a complex left cerebral subdural hematoma containing significant acute hemorrhage. R2's hospital record 3/8/23 at 10:45PM denotes R2 has known history of falls Hospital record on 3/9/23 documents R2 was intubated during operation and remains so. Post op drain and dressing indicated on R2's head. Procedures listed: cerebral angiogram for embolization, left die burr holes with placement of drain, and intubation. R2's death certificate dated 3/21/23 documents cause of death 1. Complications of closed head injury 2. Fall. 2. R1 is 67 years old with a diagnosis including but not limited to Fracture of Right Femur (5/8/23), History of Falling (5/8/23), Long Term Use of Anticoagulant, Lack of Coordination, Abnormal Posture, and Difficulty in Walking. R1's Fall Scale Evaluation dated 12/18/22 notes R1 has a fall risk scale of 51. Scoring indicates high risk is a score of 45 and higher.	S9999		

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S9999	Continued From page 19 On 6/6/23 at 12:26PM the surveyor observed R1 in his room, laying on his bed, no socks or shoes on his feet, and no floor mats in place. On 6/7/23 at 11:27AM R1 observed sitting in his room in his wheelchair. R1's floor being mopped and wet floor sign in the room. No floor mat observed in the room. On 6/8/23 at 11:40PM V13, DON, said R1 has only 1 fall incident report dated 5/10/23. V13 said I did the investigation for this fall. V13 said R1 only complained of pain on 5/3/23 while in the facility. V13 said it was written in his hospital file that while in the hospital he reported that he fell in the facility. At 12:03PM V13 said the nurse at the hospital told me R1 fell and it is in the record. V13 said 12/25/23 is the only other fall R1 had. At 12:26PM V13 said I was verbally told when R1 went to the hospital he self reported the fall at the hospital. On 6/8/23 at 1:09PM V26, LPN, said when I started my medication pass on 5/3/23 I noticed R1 was not comfortable. V26 said I noticed R1's right leg with swelling at the hip and upper leg. V26 said R1's overbed table was at the foot of the bed and that was unusual because the table was usually next to him. V26 said there were no floor mats in the room when he was assessing R1. V26 said after the X-ray was completed I was notified R1 had a right leg fracture. V26 said R1 was not acting at his baseline. V26 said R1 was often self transferring without assistance from staff and often seen reaching under his bed. V26 said R1 would sometimes take himself to the bathroom. V26 said R1 would remind him and tell him to ask for help. V26 said R1 never used the call light. V26 said R1 needs at least supervision for transfers because he was unsteady before the	S9999		

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fracture. V26 said he used an interpreter when talking to R1 about his pain. V26 said R1 said he did not know what happened to his leg. V26 said R1 was a fall risk before 5/8/23. V26 said if a patient is on the floor it is a fall.

On 6/8/23 at 1:33PM V27, Certified Nursing Assistant (CNA), said she spoke with R1 on 5/3/23 in Spanish and he only said he had pain in his leg and she told the nurse what R1 said.

On 6/8/23 3:15PM V32, CNA, was assigned to R1 on 5/2/23 evening shift. V32 said R1 tries to get out of bed. V32 said R1 thinks he can get up and assist the room mate, he sits up and tries to stand. V32 said R1 never fell on my shift. V32 said R1 tries to go from bed to wheelchair on his own and sometimes he is successful. V32 said if you see a resident on the floor it is a fall. V32 said if I saw a resident crawling around. I would report it as a fall, because I don't know how you (the person) got on the floor.

On 6/9/23 at 10:19AM V13, DON, said via a phone conversation with the hospital staff I was told R1 said he fell in the facility. V13 provided a record from the hospital that reads "I usually take steps in my wheelchair". The surveyor questioned the document because the document does not denote R1 said he fell. V13 said "I used the wrong wording on the incident report. I worded it incorrectly." The surveyor reviewed R1's previous falls and incident reports with V13. V13 said I don't want to comment on R1's fall on 12/25/22. V13 said "I can't answer the root cause". V13 said a fall is a change in plane. V13 said we have some residents with behaviors that lower themselves to the floor. V13 said if it is a behavior there will a progress note and a careplan for the behavior. V13 said the plane is majority of the

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S9999	Continued From page 21 time the floor. On 6/14/23 at 10:12AM V14, Social Services Director, said behaviors are care planned. V14 said we document behaviors on a form in the record. V14 said crawling on the floor is a behavior that would be care planned. V14 said we would collaborate with the other departments and develop interventions. On 6/14/23 at 10:57AM V22 said the floor mat interventions for R1 was implemented. V22 said I don't know when we took the floor mats out. V22 said staff should be following the care plan. V22 said R1's episodes of crawling in the room should have been investigated. On 6/14/23 at 11:53PM V40, Nurse Practitioner, said R1's baseline is confused and he sometimes follows commands and his answers may or may not be appropriate. V40 said R1 was able to transfer himself prior to the fall. V40 said R1 did not understand the risk of his movements. V40 said "it is an assumption" that R1 fell because no fall was reported. V40 was asked if R1 was a fall risk and V40 responded "of course, he was dementia and patient getting in and out if bed numerous times. V40 said everyone should be following the documented list of actions and precautions for the residents. V40 said "The staff should be checking in on him constantly, make sure he is safe and in good condition". V40 said no staff saw what happened to R1, he was just complaining of pain. V40 said I can't recall if I was notified of the fall investigation results. R1's X-Ray dated 5/3/23 denotes X-Ray Right Hip, Unilateral Impression: acute moderately comminuted intertrochanteric fracture of the proximal right femur with deformity.	S9999		

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R1's Incident Report dated 12/25/22 denotes observed lying on the floor. Notes: Sent to ER for further evaluation, Bilateral floor mats and low bed and continue therapy.

R1's Incident Report dated 5/10/23 denotes R1 with complaints of pain to right leg. No witnesses found. (There is no mention this report is related to X-ray results from 5/3/23.) This incident was reported to IDPH. Final incident report denotes "per hospital notes cause of injury related to unwitnessed fall, resident informed staff at hospital, "I usually take steps to my wheelchair".

The facility provided a document dated 5/5/23 (during R1's hospitalization period) Occupational Therapy "I usually take steps to my wheelchair".

Review of the facility Documentation Survey Reports dated 5/2/23-5/3/23 day shift have no documentation that assistance was provided with Activities of Daily Living (ADLs), including dressing and transferring.

Review of the facility provided monthly fall Logs indicate R1 had a fall on 12/25/22 and on 5/10/23.

R1's progress notes dated 12/27/22 denotes R1 is a "Very High Fall Risk due to impaired cognition and mobility." Review of R1's progress notes dated 1/9/23 denotes "checked by the CNA patient is crawling on the floor"

R1's care plan denotes he is a high risk for falls. Interventions include on 12/19/22 review information on past falls and attempt to determine root cause of falls. The facility provided a 13 page care plan and there is no mention R1 has a behavior of crawling on the floor.

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S9999	Continued From page 23 R1's hospital record dated 5/3/23 denotes "patient unable to provide meaningful history. Per EMS and nursing home report, patient had an unwitnessed fall today with persistent right hip pain". Hospital X-ray report dated 5/3/23 denotes x-ray hip 2 views right and pelvis impression: comminuted right femoral intertrochanter fracture. The facility Fall Prevention Policy effective date 11/28/2012, in part denotes the program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. The fall prevention program, includes the following immediate change in in interventions, communication with direct care staff members, documentation requirements. Care plan incorporates: addresses each fall, interventions are changed with each fall, as appropriate, preventative measures. Accident/Incident reports involving falls will be reviewed by the team to ensure appropriate care and services were provided and determine possible safety interventions. Residents will be assigned approximately every 2 hours. The fall risk interventions will be identified on the care plan. Foot wear will be monitored to ensure the resident has proper fitting shoes and/or footwear is non-skid. In addition to these of Standard Fall Precautions, the following interventions may be implemented for residents identified at risk. The frequency of safety monitoring will be determined by the risk factors and the plan of care. In the event safety monitoring is initiated for 15-30 minute periods, a documentation record will be	S9999		

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S9999	Continued From page 24 used to validate observations. Safety monitoring will be discontinued when the risk factors requiring monitoring is no longer evident. (A)	S9999		