STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005904	A. BUILDING: _____ B. WING _____	C 05/04/2023

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ELEVATE CARE COUNTRY CLUB HILL	18200 SOUTH CICERO AVENUE COUNTRY CLUB HILLS, IL 60478

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S 000	Initial Comments Complaint Investigations: 2393315/IL158955 2392898/IL158470 2392479/IL157971 Investigation of Facility Reported Incident of 03-28-2023/IL158433 Investigation of Facility Reported Incident of 03-31-2023/IL158527	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610a) 300.1210a) 300.1210b) 300.1210d)3)5)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and	S9999	**Attachment A** **Statement of Licensure Violations**	

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the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

5) A regular program to prevent and treat

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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.

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, interviews and record reviews, the facility failed to ensure that multiple sheets are not used on low air loss mattress, failed to follow treatment orders and interventions in preventing the worsening of pressure ulcer for one (R7) of three residents reviewed for pressure ulcers. This deficiency resulted in R7's pressure ulcer on the sacral region increasing in size and developing slough, necrotic tissue.

Findings include:

R7 is a 58-year-old female, initially admitted in the facility on 09/05/22 with diagnoses of Pressure Ulcer of Sacral Region, Stage 4 and Quadriplegia, Unspecified.

R7's POS (Physician Order Sheets) documented the following: 4/10/23: Sacrum: Calcium Alginate

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with Silver as needed for wound care soilage or dislodgement 4/11/23: Sacrum: Calcium Alginate with Silver every day shift for wound care. Cleanse with NSS (normal saline solution), pat dry, apply Calcium alginate Ag, cover with dry dressing.

Physician wound notes recorded the following measurements on R7's Stage 4 pressure ulcer on the sacral area:
02/03/23: 5 cm (centimeter) x 8 cm x 1.1 cm
03/02/23: 5.5 cm x 6 cm x 1.5 cm
03/09/23: 6.5 cm x 8 cm x 1.5 cm; History of Present Illness (HPI): Sacral wound size increased compared to the last visit. Surrounding skin was noted with excoriation.
03/16/23: 10 cm x 8.5 cm x 1.1 cm; HPI: Sacral wound debrided to remove devitalized tissue.
04/20/23: 8 cm x 6 cm x 1.5 cm
04/27/23: 8 cm (centimeters) x 6 cm x 1.5 cm

On 5/02/23 at 11:00 AM, V13 (Wound Care Coordinator) was observed performing wound care on R7. The sacral pressure ulcer was observed open, with current measurement of 7 cm x 5 cm x 2.8 cm. Per V13, the sacral wound is 30-40% slough, 60-70% granulation. A tan colored slough is covering almost half of the wound bed. During cleansing, the sacral wound was bleeding in minimal amount. Subsequently, the wound was treated as ordered and covered with dressing. R7 was asked if she is repositioned when in bed. R7 stated, "I'm not turned every two hours, staff don't do that. My back wound stays the same, been a while."

On 05/03/23, R7 was observed for repositioning. The following were noted:
9:20 AM - lying on back
9:40 AM - lying on back

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10:05 AM - lying on back
10:20 AM - lying on back. R7 stated she wants to get up because she wants her hair done on the first floor. Also stated that she has not been repositioned.
10:40 AM - lying on back
11:00 AM - CNAs (Certified Nurse Assistants) V6 and V21 were observed going into R7's room. V6 stated that she (R7) wants to be cleaned because she (R7) wanted to go to the first floor to get her (R7) hair done. R7 had to direct V6 to get her up. During provision of morning and incontinence care, as V6 turned her (R7) to her (R7) right side, the brief was observed wrinkled and soiled with minimal to moderate amount of blood coming from the wound. The sacral wound was exposed with no covered dressing. The incontinence pad was also wrinkled and soiled with blood. R7 was using a low air loss mattress covered with a flat sheet. On top of the flat sheet was the soiled incontinence pad. R7 was wearing an incontinence brief. V6 stated, she checked her (R7) around 9:45 AM and she was still dry. R7 verbalized, "She checked me, yes but she just asked me how I was doing and if I needed anything. She did not check my brief. She (V6) did not turn me from side to side, never ever." At 11:15 AM, V13 came to clean her wound. V13 stated, "We have PRN (when needed) treatment orders, unit nurse can change dressing when needed. CNAs need to tell nurses if the dressing is soiled or been removed during incontinence care."

On 05/03/23 at 2:47 PM, V13 was interviewed regarding R7's pressure ulcer on the sacral area. V13 replied, "CNAs should notify any new areas to unit nurse. Unit nurse should be doing skin assessment and alerting wound care. Treatment orders should be followed and implemented.

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S9999	Continued From page 5 Repositioning should be done at least every two hours at the very least. Incontinence care should also be implemented in improving wound status. For low air loss mattress, one flat sheet only. There should be no more than two layers, could be the pad or the brief. Multiple layers would inhibit the functioning of the mattress. R7 should not be wearing the brief. Wound should be covered all the time, to prevent infection. CNAs should be notifying nurses if dressing gets soiled or removed so it could be replaced." R7's care plan on actual impaired skin integrity related to skin breakdown related to decreased mobility and incontinence of bladder secondary to Cervical Spine Injury, current skin breakdown of increased severity, history of Osteomyelitis; potential for signs and symptoms of ongoing and recurrent complications of delayed healing, signs and symptoms of new breakdown, and infection, documented the following interventions: apply treatments as ordered; encourage/assist resident to change position as often as possible; keep skin clean and dry; avoid friction and shearing; specialty bed surface; incontinence briefs/pads, change PRN. V11 (Wound Nurse Practitioner) was asked on 05/03/23 at 1:51 PM about R7's sacral pressure ulcer. V11 stated, "Been seeing her for a couple of months now. She has a sacral wound, Stage 4. The wound is stable, no complications from last time I saw her, that was last 04/27/23. She was admitted with Osteomyelitis in the sacral wound. She is incontinent, immobile, and getting a lot of moisture due to her incontinence. It is not okay for the wound not to be covered. She should have a dressing and should be dry all the time. If her wound has 30-40% slough on wound bed, the slough should not be expected on the wound.	S9999		

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S9999	Continued From page 6 Presence of slough means there is dead tissue, necrotic tissue and it needs to come off by debridement or medications. V11 stated dead tissue competes with healthy tissue and needs to get out. Slough is not normal but if it's there, it is indicative that tissue is dying, and wound is not improving. Repositioning relieves pressure on the wound and helps in healing." Wound progress notes dated 05/04/23 recorded: Wound measurements sacrum - 8.0 cm x 7.0 cm x 1.5 cm. Manufacturer's guidelines for the use of the low air loss mattress stated in part but not limited to the following: Operating Instructions Step 5 Patients can directly lie on the mattress or cover with a sheet and tuck loosely to increase the comfort of the patient. Facility's policy titled "Pressure Ulcer Prevention" revision date 1-15-18, documented in part but not limited to the following: Purpose: To prevent and treat pressure sores/ pressure injury. Guidelines: 4. Keep bottom sheet dry and tightly stretched and free of wrinkles. 5. Turn dependent resident approximately every two hours or as needed and position resident with pillow or pads protecting bony prominences as indicated. (B) Statement of Licensure Violations 2 of 2: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)3)6) Section 300.610 Resident Care Policies	S9999		

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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 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the

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S9999	Continued From page 8 resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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.	S9999		

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S9999	Continued From page 9 These requirements were not met as evidenced by: Based on interviews and record reviews the facility failed to follow their policy and procedures for fall prevention by not having effective fall interventions, not completing fall evaluations for each fall occurrence to determine root causes of falls, and to ensure proper transfer procedures were implemented for a resident who is totally dependent on staff for transfers. This failure applied to three of three residents (R4, R5, and R9) reviewed for accidents and supervision which resulted in R4 sustaining a spine fracture, R5 sustaining a leg fracture, and R9 experiencing repeated falls. Findings include: R4 is a 97-year-old female with a diagnoses and history of Unspecified Injury of Face Subsequent Encounter (as of 03/02/23), Unspecified Injury of Head Subsequent Encounter (as of 03/02/23), Head Bruise Subsequent Encounter (as of 03/02/23), Dementia without Behavioral Disturbance, History of Falling (as of 03/02/23), Abnormalities of Gait and Mobility, Lack of Coordination, and Late onset Alzheimer's Disease who was admitted to the facility 03/02/23. R4's most current physician orders included an active order effective 3/2/2023 for 10mg Donepezil (Cognition Enhancing Medication) by mouth at bedtime for Alzheimer. R4's care plan initiated 03/02/23 documents she is at risk for falls related to unawareness of safety needs, decreased mobility, and recent history of falls with injury with interventions including assure the floor is free of glare, liquids and foreign	S9999		

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objects; continue with physical therapy for strengthening, encourage appropriate use of assistive device as applicable, utilizes wheelchair, keep call light and desired personal items within reach, maintain an environment free of clutter, observe for changes in ability to ambulate and/or move about, psych evaluation, recommend that resident use proper footwear, staff will offer and assist patient to rest in bed when noted restless in wheelchair.

R4's care plan initiated 03/08/23 documents she is disoriented to person/place/time. Her memory is impaired. She has problems with decision-making, insight, logic, calculation, reasoning, planning, organization, sequencing, social skills and/or judgement. This problem is related to: diagnosis of Dementia with interventions including provide clear explanations regarding expectations and procedures prior to providing care; break tasks down into small, manageable sub-tasks.

R4's progress note dated 3/4/2023 at 1:49 PM documents family stressed sun downs and Dementia, reassurance given to family and resident remained sitting up in chair at bedside with no attempts to get up.

R4's fall scale evaluations dated 03/02/23, 03/05/23 and 03/30/23 documents she is a high risk for falls with a score of 75 with risks including an impaired gait and a history of falling.

R4's post fall observation dated 03/30/23 documents she experienced an unwitnessed fall in the hallway; just prior to fall she was sitting during an unknown activity and using her wheelchair at the time, she was unable to state what happened, no injuries were noted.

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R4's progress note dated 3/30/2023 12:20 AM documents writer received patient at the nursing station. Patient was very agitated and wouldn't stay in her wheelchair. Patient was hitting the staff, screaming and biting the staff. Family was called and the physician was made aware and asked that the patient be sent out to the hospital; at 6:13 PM documented resident noted sitting at the nurses station in wheelchair screaming, staff attended to all needs and resident was redirected several times. Writer was assisting EMS (Emergency Medical Services) and upon turning to check on resident she was noted on the floor near nursing station screaming and yelling. R4 was noted sitting on her buttocks with the wheelchair sitting behind her. Family requested patient be sent out to emergency room for the fall.

R4's progress note dated 3/31/2023 at 08:56 AM documents she was transferred to the hospital due to unwitnessed fall, call placed to hospital. Spoke with nurse at hospital who stated that patient was transferred to another hospital due to cervical fracture. Call placed to other hospital, spoke with nurse who stated that R4 will be admitted for confusion, cervical fracture with cervical collar in place and degenerative changes. Per hospital nurse R4 currently in restraints due to multiple behaviors as she attempted multiple times to get up and is pulling at cervical collar.

Facility's Final Incident Investigation Report dated 04/05/23 documents on 03/30/23 R4 was observed sitting up in her wheelchair by the nurses station and was redirected multiple times after attempting to get up from her wheelchair and self-transferring by wheelchair away from the nurses station. R4 was noted to be yelling at staff.

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S9999	Continued From page 12 Before staff was able to reach her, she stood up and was observed sitting on the floor across from the nursing station. R4 displayed impulsive behavior during the incident and had no safety insight or safety awareness related to diagnoses. R4 was sent to the hospital emergency room for evaluation and a CT scan revealed a cervical fracture. R4's Hospital Record dated 03/30/23 documents she presented at the emergency room after an unwitnessed fall at the facility and was receiving care from a sitter while exhibiting increased agitation. On 05/03/23 from 10:36 AM - 11:26 AM V15 (Licensed Practical Nurse) stated R4 was calmer in the morning but exhibited sundowning daily from 2PM - 11PM. V15 stated R4's sundowning behavior included screaming, not wanting to go to bed or be changed, wanting to walk when she can't, and not wanting to be talked to. V15 stated some days it's possible to get R4 to sit at the nurse's station by her and talk or keep her busy with things like sorting papers or writing stuff out or talking to her about Trinidad and what she liked to do or eat. V15 stated there's always two nurses and four CNA's (Certified Nursing Assistants) that typically work during the 3- 11/11:30 PM shift. V15 stated R4 never refused medication. V15 stated when she arrived to work at 3PM 03/30/23 R4 was already screaming. V15 stated when R4 is sundowning she thinks someone is trying to kill her, and says things like why am I here, and doesn't want anyone to touch her. V15 stated R4 fell around the middle of her shift. V15 stated during the time of R4's fall it was between 6-8 PM during the time medications are being passed and residents are being placed in bed. V15 stated she only remembers her and R4 being at the	S9999		

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nurse's station during the time of her incident. V15 stated when R4 fell she had just received a new patient in the facility that had been brought in by EMS (Emergency Medical Services) personnel. V15 stated while she was looking down at documents and completing and signing paperwork for the new resident the EMS driver began communicating with her while he was getting on the elevator. V15 stated she turned her head towards the EMS to communicate with him and when she turned back toward R4 she was on the floor. V15 stated just before R4 fell she was calm and in a low tone asking for her daughter, grandson, and expressing she wanted to go home.

V15 stated when the residents come from dinner, the ones who are fall risks are placed by the nurse's station and R4 was sitting by the nurse's station during her incident. V15 stated R4 had refused to be changed so the staff were giving her time before reattempting. V15 stated several times before R4 fell she had to be redirected because she was attempting to get up out of her wheelchair and was up and out of the chair a few times. V15 stated staff had to run over and catch R4 because she was getting out of her chair. V15 stated in order for R4 to comply with sitting down in her wheelchair you have to go over to her or be right next to her. V15 stated R4 was a few feet away on the other side of the nurse's station between the medication room and the water fountain when she fell. V15 stated R4 was not within her reach when she fell. V15 stated she was passing medications when the new resident arrived and had to go and get the paperwork for the new resident and was not directly next to R4 at the time of her fall. V15 stated if she was closer to R4 when she fell, she would have seen her attempting to get up and been able to redirect

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S9999	Continued From page 14 her. On 05/03/23 from 12:24 PM - 1:50 PM V1 (Administrator) stated residents are supervised from the nurse's station. V1 stated the adequacy of supervision for a resident would depend on the entire plan of care including supervision and depending on the resident's behavior. V1 and V4 (Assistant Director of Nursing) stated R4 may not have been adequately supervised based on her reported behaviors of repeatedly attempting to get out of her chair prior to her fall on 03/30/23 and the nurse reporting R4 will only comply with redirection to remain in her chair when someone is directly next to her. V1 and V4 agreed that it was unlikely that V15 (Licensed Practical Nurse) could reach R4 in time to break her fall based on her distance from the nurse and the barrier of the nurse's station between her and the nurse during the time of her fall on 03/30/23. V1 and V4 agreed that R4's distance from the V15 during the time of her fall could have contributed to her fall. V1 and V4 agreed that V15 turning her head away to attend other duties during the period of time of R4's fall after R4 had been exhibiting behaviors of repeatedly trying to get out of her chair could have contributed to her fall on 03/30/23. R5 is an 84-year-old male with a diagnoses history of Partial Paralysis following Stroke, Vascular Dementia without Behavioral Disturbance, History of Falling (as of 08/31/21), and Anxiety Disorder who was originally admitted to the facility 06/08/2021. R5's Quarterly Minimum Data Set dated 01/18/23 documents he requires total dependence on two staff for transfers, extensive one person assistance for bed mobility and toileting.	S9999		

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R5's most current care plan initiated 06/29/22 documents he has the potential for vision impairment related to blindness in the left eye; potential for impaired safety with interventions including implement and maintain safety precautions. Tell him (R5) where you are placing his items. R5's most current care plan initiated 06/08/21 also documents he is at risk for falls related to Gait/balance problems, Psychoactive drug use, cognitive deficits, history of falling, CVA Left sided weakness, poor safety awareness, impulsive, limited mobility, poor vision, Anxiety Disorder. R5 has had a fall with no injury on 12/8/21; and he sustained a fall with no injury on 7/24/22 with interventions including: ensure resident is positioned and aligned in the middle of bed; anticipate and meet R5's needs; be sure R5's call light is within reach and encourage him to use it for assistance as needed, R5 needs prompt response to all requests for assistance; Ensure resident is positioned correctly in wheelchair; Ensure that R5 is wearing appropriate footwear when ambulating or mobilizing in wheelchair; he will have a dycem applied to his chair to prevent slipping out of chair. Review information on past falls and attempt to determine cause of falls; record possible root causes; alter remove any potential causes if possible. Educate resident/family/caregivers/ and interdisciplinary team as to causes.

R5's most current care plan initiated 07/22/22 documents he requires use of full body lift for transfer with diagnoses history including partial Paralysis and Dementia.

R5's most current care plan initiated 01/06/23 documents he is at risk for falls due to Confusion, Incontinence, Poor

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communication/comprehension, Psychoactive drug use, unaware of safety needs; with diagnosis of partial paralysis following cerebral infarction, vascular dementia, and anxiety disorder with interventions including keep furniture in locked position; Keep needed items, water, etc. in reach; maintain a clear pathway, free of obstacles. Avoid repositioning furniture.

R5's progress note dated 03/25/2023 9:15 PM documents CNA (Certified Nursing Assistant) reported to writer patient complaining of pain to right lower extremity. Patient voiced having pain to right leg while being transferred back to bed and during peri care. Assessment completed noted right lower extremity with very painful range of motion. Patient is unable to straighten his right leg and hip/femur is swollen and tender to touch. This writer noted patient sitting up in the chair when arrived this morning. Patient did not complain of pain during day shift and most of PM shift until placed back in bed. Patient screamed out in pain with movement of the right lower extremity. Page placed for the Nurse Practitioner. No incidence of a fall reported for this resident; 10:13 PM progress note documents spoke with Nurse Practitioner; order received to send the patient out to the emergency room. R5's 11:15 PM progress note documents patient with complaints of severe pain to the right hip and femur. Per CNA (Certified Nursing Assistant) patient normally can move right lower extremity and straighten leg on his own without assistance without pain; noted right hip area swelling with excess fluid with pain upon physical medical assessment. Recommendation was to send the resident out to emergency room for evaluation.

R5's progress note dated 3/26/2023 09:49 AM documents resident returned from hospital with

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S9999	Continued From page 17 no new orders alert and awake. No abnormal musculoskeletal findings were observed in hospital assessment. Resident was administered as needed pain medication and transferred to chair to eat breakfast in dining room. R5's 7:38 PM progress note documents that upon further observation of hospital discharge records writer observed that resident refused x-ray of right hip at hospital. Resident continuously complains of pain of right hip. Writer recommends x- ray of right hip. Writer left message for on call service for update, no call back at this time. R5's progress note dated 3/27/2023 10:07 AM documents new orders given by Nurse Practitioner for immediate x-ray to right hip due to complaints of pain. R5's progress note dated 3/28/2023 10:28 AM documents: resident complained of pain when right leg moved, Nurse Practitioner present at facility and examined resident, new orders received for immediate x-rays. R5's 12:03 PM progress note documents x-ray results relayed to Nurse Practitioner of right thigh fracture. New orders to send to hospital. R5's Hospital Record Dated 03/28/23 documents he was admitted for an unwitnessed fall, nontraumatic fracture of right hip, came from nursing home and is not able to give history, was seen in the emergency room two days prior due to right hip pain, it appears that an x-ray was not done at the time of initial presentation to the hospital, an x-ray was performed during this visit to the hospital and revealed a right thigh fracture. R5's progress note dated 3/29/2023 09:49 AM documents he was admitted to the hospital with a diagnosis of Right Thigh Fracture.	S9999		

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R5's March 2023 Medication Administration Record documents he was assessed to have a pain level of 7 during the evening shift on Saturday 03/25/23 and during the morning shift on Sunday 03/26/23, and a pain level of 0 from the evening shift on Sunday 03/26/23 - the morning shift on Tuesday 03/28/23.

Facility's Final Incident Investigation Report dated 04/03/23 documents on 03/25/23 while providing bedtime care for R5 CNA (Certified Nursing Assistant) observed swelling to R5's right hip, the inability of R5 to straighten his right leg, and appeared to be in pain with movement. R5's Nurse Practitioner was notified, and an order was given to transfer him to the hospital emergency room. On 03/28/23 he was examined by the Nurse Practitioner and an immediate x-ray was performed and revealed an acute right thigh fracture. An order was given to send R5 to the hospital emergency room for further evaluation and treatment. R5 was determined not to have a fall based on interviews with staff and other providers. V16 (Family Member) visited on 03/24/23 and reported no fall incidents. R5 underwent right hip surgery on 03/28/23 at the hospital and remains hospitalized at the time of this report; V22 (Certified Nursing Assistant) was interviewed and stated on 03/25/23 later on during the shift R5 complained of right hip pain when being moved after being transferred to his bed while receiving bedtime care, he was observed with swelling in right hip area and was unable to straighten his leg, the nurse was informed of his condition. A Disciplinary Report dated 03/30/23 included in the investigation packet documents V22 failed to follow care instructions for a resident during transfer and received an immediate warning; a non-dated in-service included in the investigation packet

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documents V22 was in-serviced regarding following resident's transfer status and care plan; there were no resident interviews other than R5 included in the investigation reports nor any documentation that there were no residents who may have had any direct knowledge of the incident.

On 05/03/23 from 12:24 PM - 1:50 PM V1 (Administrator) stated while investigating an injury of unknown origin staff would be interviewed regarding interactions leading up to an injury of unknown origin. V4 (Assistant Director of Nursing) stated you can also interview family, the patient themselves and other residents if they are cognitively able to provide information to determine if they have any information on the potential cause of the injury of unknown origin. V1 stated even if the facility is unable to determine the exact cause of an injury of unknown origin after investigating the cause of the injury, the resident's injury is still the facility's responsibility.

On 05/04/23 from 10:27 AM - 10:43 AM V9 (Licensed Practical Nurse) stated R5 did not complain of pain on Friday 03/24/23 when she worked. V9 stated she was off Saturday and Sunday 03/25/23 and 03/26/23. V9 stated when she came back to work on Monday 03/27/23 R5 complained of pain in his legs and an x-ray was done at the facility, but it was inconclusive. V9 stated R5 was still complaining of pain on Tuesday 03/28/23 and the Nurse Practitioner saw him in person and ordered another x-ray. V9 stated another portable in-house x-ray was done on 03/28/23 and it revealed a fracture. V9 stated it seemed like R5's injury happened over the weekend because he did not complain of pain prior to this. V9 stated she believes R5 went to the hospital on 03/25/23. V9 stated R5 only

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complained of pain when being moved. V9 stated whenever R5's fractured leg was touched then he would report pain. V9 stated R5's complaints of pain were not constant. V9 stated R5 may have a diagnosis of Chronic Pain but did not usually ask for pain medications which is why his complaints of painleading up to the discovery of a fracture was unusual. V9 stated R5 requires transfer by mechanical lift. V9 stated R5 is usually up in either a reclining chair or high back wheelchair, but she can't be sure which type of chair. V9 stated R5 is normally gotten up daily and has breakfast and remains out of bed. V9 stated R5 is also changed throughout the shift and is placed back in bed in the evening.

On 05/04/23 from 1:44 PM - 2:03 PM V4 (Assistant Director of Nursing) stated the nurse should have attempted again to reach out to the doctor to see if R5 would be receptive to being x-rayed after the nurse observed him to be in continuous pain and made an attempt to reach the physician on the evening shift 03/26/23. V4 stated she can't explain what R5's outcome might be from the lack of additional attempts by the nurse to reach the physician on 03/26/23. V4 stated she is not sure why R5's March Medication Administration Record documented pain levels of 0 from the evening of 03/26/23 - the evening of 03/28/23 although his progress notes from 03/26/23 indicated he was in continuous pain. V4 stated she cannot explain how R5 may have sustained his fracture if he didn't fall while in the facility.

R9 is an 81-year-old male with a diagnoses history of Partial Paralysis following a Stroke, Repeated Falls (present on admission), Dementia without Behavioral Disturbance, Degenerative Disease of the Nervous System and Blindness

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S9999	Continued From page 21 who was admitted to the facility 07/08/22. On 05/02/23 at 2:19 PM R9 was observed lying in his bed listening to the television. Observed R9 was observed wearing regular socks and R9 had floor mats on both sided of R9's bed. From 05/01/23 - 05/03/23 during the course of the complaint survey while making rounds suveyor did not observe R9 out of his bed and or participating in activities. R9's current care plan initiated 08/29/22 documents he is at high risk for falls related to gait/balance problems, history of falls, and impaired vision with interventions including staff to monitor for altered mental status or acute infection, encourage to call for assistance before attempting to toilet self or transfer, offer and assist to lay down after meals, psych evaluation (initiated 02/28/23), Encourage activities that minimize the potential for falls while providing diversion and distraction, Encourage to participate in activities that promote exercise and physical activity for strengthening and improved mobility, and Physical Therapy to evaluate and treat as ordered or as needed. R9's current care plan initiated 10/03/22 documents he demonstrates behavioral distress as manifested by Verbally abusive behavior; Use of profanity, demeaning statements, verbal threats, and yelling; Racial/ethnic/religious/gender slurs. With interventions including Ask the resident to calmly explain what is causing this upsetting behavior. Praise the resident for speaking calmly and appropriately, If the resident becomes verbally or physically abusive, attempt to calm the resident, by explaining that "ladies and gentlemen" do not talk or behave this way.	S9999		

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R9's current care plan initiated 08/05/22 documents he exhibits the symptoms of rejecting care, places self on ground as a behavior if immediate attention is not given, with interventions including evaluate when the best time of day is to provide care. Provide care consistent with the person's "schedule," as possible, give psychoactive medication, as ordered, refer the resident to the consulting psychiatrist for a psychiatric evaluation, as warranted, staff will encourage safe coping skills to help avoid possible falls due to behaviors. R9's current care plan initiated 10/22/22 documents the resident presents with signs and symptoms of Delirium such as recent onset or worsening of symptoms, including becoming easily distracted; paranoia, periods of altered perception/awareness inattention; episodes of disorganized speech; periods of restlessness; periods of lethargy; mental function varying over course of the day. Signs and symptoms are related to: Dementia with interventions including Review medical and psychosocial evaluations to assess potential delirium causes and contributing factors. Delirium is typically caused by several factors. Rule out serious illness/worsening of an acute illness; Review medication interactions. Look for drug toxicity, Review medication and food interaction, Check food and fluid intake. Review weight records.

R9's Fall Evaluations from Admission to Current document he is a high risk for falls.

R9's progress note dated 08/26/22 documents R9 was observed yelling out repeatedly help me help me I'm on the floor, exhibited signs of confusion and behaviors and it was endorsed to shift to request a psych consult.

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S9999	Continued From page 23 R9's Post Fall Observation dated 08/26/22 11:30 AM documents he experienced an unwitnessed fall while lying in his bed engaging in leisurely activity in his room. Resident was reaching for call light. R9's progress note dated 10/7/2022 2:05 PM documents patient observed on the floor in his room in a side lying position on the side of the bed. Resident stated that he was attempting to go to the bathroom. Resident with complaints of pain to the right knee. R9's Post Fall Observation dated 10/7/2022 12:40 PM documents he experienced an unwitnessed fall while sitting in his room. Resident stated he was trying to go to the washroom. He experienced pain in his right knee and was provided pain medication. R9's progress note dated 12/22/2022 11:58 AM documents R9 has had a recent fall. Please refer to the Post Fall Observation for details. R9's Post Fall Observation dated 12/22/22 11:58 AM documents he experienced a witnessed fall while sitting in the lounge or dayroom engaging in leisurely activity. R9 stated he was trying to get in his wheelchair to go to bed. R9's progress note dated 12/22/2022 5:03 PM documents at 4:43PM writer notified by day nurse that resident is sitting next to bed on the floor upright, writer walked into room with male certified nursing assistant and noted resident attempting to get up. R9 stated he was reaching for his phone and just sat on floor because felt he was going to fall. R9's Post Fall Observation dated 12/22/22 4:43	S9999		

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S9999	Continued From page 24 PM documents he experienced an unwitnessed fall while in his room lying in bed. R9 stated he was reaching for his phone and just sat on floor because felt he was going to fall. R9 was wearing skid grip socks at the time. R9's progress note dated 12/28/2022 12:57 AM documents writer notified by certified nursing assistant that resident is sitting next to his chair in the day room. Writer walked into room with staff nurses on the floor and noted resident attempting to get up. R9 stated he tried to slide to the floor. R9 started shouting profanity at the staff. Requesting psych evaluation. R9's Post Fall Observation dated 12/28/2022 1:06 PM documents he experienced an unwitnessed fall while sitting in the dayroom or lounge. The resident stated he slid himself onto the floor from his wheelchair. R9's Nurse Practitioner progress note dated 1/2/2023 9:59 PM documents Chief Complaint of Multiple falls. Patient asked to be seen due to multiple falls. Patient sustained a fall twice in a week, noted to be due to behavior issues. R9's progress note dated 1/4/2023 10:02 PM documents Chief Complaint of Multiple falls, now with increased behavior issues. Patient was seen resting on his bed, agitated and anxious at the visit. Patient trying to get up from his bed walk independently, was redirected back to the bed. Patient had sustained to fall recently, will check labs. Assessment and Plan includes increased behavior issue. Other etiology could be worsening dementia as well. Accusing staff of stealing his belongings. Patient with attention seeking behavior.	S9999		

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S9999	Continued From page 25 R9's progress note dated 1/21/2023 3:32 AM documents R9 has had a recent fall. Please refer to the Post Fall Observation for details. R9's Post Fall Observation dated 1/21/2023 03:32 AM documents he experienced an unwitnessed fall while in his room lying in his bed sleeping, he was wearing regular socks at the time. R9 reported "I don't know what happened" and "I was trying to get up." R9's progress note dated 2/15/2023 8:12 PM documents Resident is threatening to drop himself on the floor if service request isnt done on time. R9 called a certified nursing assistant for help to get changed but a certified nursing assistant was busy with another patient. R9 pushed himself to the floor to get a quicker response. R9's progress note dated 2/18/2023 6:33 PM documents approximately 6:20 PM during med pass. Writer was reported to by certified nursing assistant that she observed patient lying supine on the floor in the hallway. Writer went to assess R9, and he was still lying supine. R9 was unable to verbalize how he had fallen. R9 unable to verbalize where he was experiencing pain. Nurse Practitioner was notified, verbal order to send R9 to the hospital emergency room. R9's Hospital Record dated 02/18/23 documents he presented to the hospital emergency room from the facility after an unwitnessed fall. R9 was found in the hallway on the ground. Per the emergency medical services personnel R9 stated at the time he was hurting all over. The hospital Registered Nurse spoke with the facility Registered Nurse, and it was reported that he was in significant pain after the fall.	S9999		

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R9's progress note dated 2/24/2023 10:04 AM documents Alerted to residents' room, observed resident laying on floor alert verbal complaints of right sided rib pain, resident also stated he bumped his head, R9 is going to be transferring to the hospital emergency room.

R9's progress note dated 2/28/2023 07:05 AM documents writer found the resident on the floor upon shift rounds. Resident has confused mental state. Contacted the physician, suggests the resident is sent out for psych evaluation. R9 was transported to the hospital.

R9's progress note dated 3/27/2023 5:27 PM documents resident was angry and tried to get out of the bed without any assistance from staff. Resident was observed with his feet on his floor mats sliding himself onto the floor mat. Resident stated he wanted to walk by himself. Resident was re-oriented to ring his call light for assistance out of his bed.

R9's progress note dated 3/29/2023 7:18 PM documents Resident was angry and tried to get out of bed without staff assistance. Resident was observed sitting on his floor mat.

R9's progress note dated 4/2/2023 2:29 PM documents Writer called to sitting area that resident observed sitting on floor upright.

R9's Post Fall Observation dated 4/2/2023 2:31 PM documents he experienced an unwitnessed fall while sitting in the dayroom or lounge during a leisurely activity. He was wearing regular socks at the time.

R9's progress note dated 4/18/2023 6:26 PM

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documents R9 has had a recent fall. Please refer to the Post Fall Observation for details; at 6:52 PM Resident slid himself onto the floor in a rage. The resident was transported from the floor to the wheelchair.

R9's Post Fall Observation dated 4/18/2023 6:26 PM documents he experienced a witnessed fall while sitting in the dayroom or lounge during a leisurely activity. Resident stated he was upset he didn't receive a snack immediately and slid himself on to the floor.

There were no post fall evaluations completed for R9's falls on 02/15/23, 02/18/23, 02/24/23, 02/28/23, 03/27/23, and 03/29/23.

R9's Behavior Diagnostic Assessment dated 04/05/23 documents he is stressed about his money and whether his daughter is taking good care of it, he reports symptoms of frequent depression and less frequently anxiety; staff reports he can be impulsive and this has led to his falling on a few occasions; he is open and receptive to talking with therapist; patient has some dementia but will likely benefit from therapy to cope with losses and his anxiety.

R9's Psychological Services Progress note dated 04/20/23 documents he reported being unable to sleep well at night, he sometimes gets very drowsy and has to go lay down. His plan includes visiting with him again in two weeks and provide support as he is coping with the loss of independence particularly his daughter managing his money and his need to get assistance with his ADL's (Activities of Daily Living), will provide an outlet for patient to talk about his concerns. Sessions scheduled every two weeks. R9 expressed appreciation for the opportunity to talk

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with therapist.

On 05/04/23 at 10:22 AM R9 stated he does feel sad and depressed, and it does make him sad that he can't move around the way he used to. R9 stated if he could get a long a little better it would make him feel better. R9 stated he wants to be gotten out of bed and wants to be moved around. R9 stated he would like to be moved around a little more. R9 stated the facility doesn't get him out of bed very often.

On 05/03/23 from 12:24 PM - 1:50 PM V1 (Administrator) stated residents are supervised from the nurse's station or if in the television room they are supervised by staff present in the area. V1 stated the adequacy of supervision for a resident would depend on the entire plan of care including supervision and depending on the resident's behavior. V1 stated supervision is adequate for R9 because they can't prevent him from falling and cannot restrain him or limit his movements. V1 stated even though R9 has had repeated falls they were different every time and involved things like sliding, agitation, and reaching. V4 (Assistance Director of Nursing) stated most of R9's falls have been behavioral and if he couldn't get his demands met, he would slide down. V1 stated each fall is discussed as an IDT (Interdisciplinary Team) and interventions are implemented to address the cause of each fall. V4 stated a fall observation evaluation should be completed for each fall. V1 and V4 stated they cannot explain why there were no post fall reports for R9's falls on 02/18/23, 02/24/23, or 02/28/23. V4 stated R9 will call for assistance to go to the bathroom if you remind him to. V4 stated on 12/22/22 in the morning R9 may have been impatient with being changed due to having to wait while staff assist residents after meals and

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decided to transport himself to the bathroom. V4 stated if a resident wants to be changed and has to wait regardless of their cognitive status it is reasonable, they may become upset and attempt to transfer themselves to the bathroom. V4 stated a change of plane is a change of plane meaning from one surface to another. V4 stated therefore if R9 did move from his bed to the floor on 03/27/23 and 03/29/23 these would be considered falls related to his behaviors. V4 stated fall procedures would have been implemented for those incidents including a post fall report. V1 and V4 stated there should have been some identification and implementation of a fall intervention for R9's fall on 04/02/23. V1 stated an intervention that would be appropriate for R9's fall on 04/18/23 when wanting a snack is to anticipate his needs. V1 stated R9 prefers outside food from his daughter. V4 stated it's difficult to anticipate R9's needs regarding snacks because he does not have a routine behavior for snacking. V4 stated it's difficult to determine what the exact circumstances of R9 wanting a snack was on 04/18/23 because it was not documented whether he was offered a snack and became impatient. V1 stated R9's fall interventions are not effective. V1 stated if a psych evaluation would have been completed for R9 as documented in his fall care plan and revealed any beneficial information regarding factors contributing to his falls it should have been added to his care plan.

On 05/04/23 from 1:44 PM - 2:03 PM V1 (Administrator) stated there could be an issue if R9 did not receive a psych consult when originally identified as being needed in August 2022 and December 2022 as documented in his medical records. V1 stated the facility did have a turnover with psych providers during that time. V4 stated if she noticed any changes in R9's behavior she

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would just refer him to psych but can't answer as to whether herself, the nurses or the nursing staff would be able to recognize whether R9 had any sadness, depression, or concerns with his lack of or decline in independence. V4 stated if it was determined that R9 was exhibiting sadness and depression after receiving a psych evaluation, any recommendations that were provided based on the psych evaluation would have been implemented in his care plan as part of fall prevention. V4 stated if she received information that R9 expressed sadness and concerns about losing his independence this could contribute to his falls, but he is also receiving medication to help with his depression and sadness. V4 stated all residents should be in non-skid socks if not wearing gym shoes. V4 stated she is not sure why R9 was wearing regular socks during his falls on 01/21/23 and 04/02/23. V4 stated R9 could have been wearing regular socks based on the time of day it was. V4 stated R9 could have been wearing regular socks during those incidents because he was just getting up for the day. V4 stated if R9 wants regular socks on while in the bed he can wear them. V1 stated she doesn't know what R9's preferences are as far as regular socks. V4 stated the purpose of no skid socks is to try and prevent residents from slipping and falling. V4 stated if it's R9's preference to wear regular socks it should be noted in his care plan or medical record. V4 stated no skid socks should be a part of R9's care plan. V1 and V4 stated the more information available related to root causes of R9's falls the better. V1 stated R9's fall intervention of encouraging activities that minimize the potential for falls while providing diversion and distraction means having R9 involved in activities throughout the day in a supervised setting. V1 stated she'll have to check and see if R9 refuses to attend activities. V1

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stated R9's behavior intervention of asking the resident to calmly explain what is causing this upsetting behavior would not be necessary to implement for R9 unless he exhibited this behavior. V1 stated R9's behavior intervention for if he becomes verbally or physically aggressive is attempting to calm him and explain what is not appropriate behavior would be more responsive than preventative since they can't predict when R9 would exhibit this behavior.

There was no documentation in R9's medical records that he refused no skid socks or preferred regular socks.

The facility did not provide R9's Fall Observation Assessments for 08/26/22, 10/07/22, 12/22/22, 12/28/22, 01/21/23, 04/02/23, and 04/18/23 requested on 05/03/23.

The facility's Comprehensive Care Plan Policy reviewed 05/04/23 states:
The Purpose of the policy is "To develop a comprehensive care plan that directs the care team and incorporates the resident's goal's, preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being."

"The facility will develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives to meet a resident's medical and nursing needs that are identified in the comprehensive assessment."

"The comprehensive care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest

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practicable physical well-being. Any services that would otherwise be required but are not provided due to the resident's exercise of rights, including the right to refuse treatment.

The facility's Fall Prevention Program Policy reviewed 05/04/23 states:
The Purpose of the policy is "To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individuals 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 components:
Care Plan Incorporates: Identification of all risk/issue, address each fall, interventions are changed with each fall as appropriate, preventative measures."

"Fall/safety interventions may include but are not limited to:
The resident's personal possessions will be maintained within reach when possible. These items include phone; Residents at risk of falling will be assisted with toileting needs as identified during the assessment process and as addressed on the plan of care; Footwear will be monitored to ensure footwear is non-skid."

"In addition to the use 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 resident's risk factors and the plan of care."

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