STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007322	A. BUILDING: _____ B. WING _____	C 06/06/2023

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AVANTARA EVERGREEN PARK	10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805

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S 000	Initial Comments Complaint Investigations: 2393867/IL159668 2393454/IL159141 2393360/IL159036 2395177/IL159917 2393722/IL159505 Facility Reported Incident Investigations: FRI of 04/21/23/IL159258 FRI of 05/05/23/IL160027	S 000		
S9999	Final Observations Statement of Licensue Violations (1 of 2) 300.610a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to monitor and supervise residents with impulsive restless behavior and poor judgement, failed to ensure residents at risk for falls wore non-slip footwear, and failed to ensure direct care staff were aware of residents who were at risk for falling. This affected 3 of 3 (R7, R5, R2) residents reviewed for falls and fall	S9999		

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S9999	Continued From page 2	S9999		

prevention. This failure resulted in R5 falling to the floor after an incident of restless behavior sustaining a facial laceration. R2 was involved in a fall incident without wearing non-slip footwear sustaining fractures to the 8th-10th ribs. R7 fell from the bed sustaining an impacted comminuted fracture of the nasal bone.

The findings include:

On 5/3/23 at 2:38 PM, V7 Licensed Practical Nurse (LPN), said CNAs are notified of fall risk by the red wrist band the resident wears.

On 5/5/23 at 12:13 PM, V10 Fall Coordinator, said each resident fall is investigated and an intervention should be added to prevent falls.

On 5/16/23 at 12:15 PM, V28 Registered Nurse (RN), said the staff is made aware of who is a fall risk by the use of the care cards inside the residents' closet. V28 said the CNA binder does not include fall risk residents.

On 5/16/23 at 1:46 PM, V10 Fall Coordinator, said the CNAs are made aware of residents at risk for falls by the binder at the nurses' station. V10 said the restorative CNA will review the binder with the CNAs. V10 said the nurses should know about the binder. Additionally, V10 said we use blue wrist bands to identify fall risk residents.

On 5/16/23 at 1:25 PM, the surveyor observed R5 and R7's closets for safety interventions card. The card observed only shows Activity of Daily Living Status, including transfers, and diet orders. None of the 3 cards includes fall prevention interventions or fall risk status.

On 5/16/23 at 2:05 PM, the surveyor observed R7

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S9999	Continued From page 3 had no dark blue wrist band. While walking to the unit with V10 she said she has been putting the bracelet on anyone who falls. Observation made with V10, R7 has no dark blue wrist band on. V28 RN, at R7's bedside when V10 asked V28 if R7 has a blue wrist band on and V10 said "no." On 5/18/23 at 10:18 AM, V12 Director of Nursing, said a blue band identifies the fall risk residents. 1. R5 is 96 years old with diagnosis including but not limited to Gout, Anxiety Disorder, Insomnia, Depression, History of Falling, Dementia, and Seizures. On 5/5/23 at 11:03 AM, V14 Nurse, said R5 has dementia and agitation, and we know to monitor him continuously. V14 said at 5:00 AM, the Certified Nursing Assistant (CNA), was in a room giving another patient care. V14 said at 5:00 AM, I was getting ready to start my medication pass. V14 said while passing medications, I was 3 rooms away from R5's room when I heard the alarm sound. V14 said I went into the room, R5 was agitated and trying to get out of bed. V14 said R5 was really agitated, he wanted his shoes. V14 said I redirected him, he was confused. V14 said R5 laid back down in the bed. V14 said I resumed my medication pass. V14 said I was 4 or 5 rooms away from R5's room and again heard R5's alarm sounding. V14 said this time the CNA made it to the room before me. R5 was laying on the side of the bed on the floor. V14 said R5 had a laceration to his left lateral eye. On 5/5/23 at 12:13 PM, V10 Fall Coordinator, said on 4/21/23 R5 fell and got a laceration over his eye. V10 said the CNA, who V10 does not know by name and thinks may have been agency staff, said R2 "was asking for shoes." V10 said	S9999		

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S9999	Continued From page 4 R5 was a known fall risk resident prior to 4/21/23. V10 said if a resident is restless, has Dementia, and is a fall risk the staff should not leave him alone in bed. V10 said R5 "is persistent" if he was awake they should have got him up in the wheel chair. V10 reviewed R5's fall report dated 11/15/22 and R5's fall care plan. V10 said I don't know the cause of R5's fall on 11/15/22 and the care plan has no intervention for November 2022, but June and July 2022 are listed. R5's Fall Risk Evaluation dated 11/14/22 notes a score of 13, high risk. Review of R5's Fall report dated 11/15/22 notes R5 observed laying on mat at bedside. Post Fall Investigation record documents unwitnessed fall without injury. The root cause analysis documents R5 was attempting to transfer without alerting staff. The resident has a BIMS of 3 with poor safety awareness. Interventions documented in care plan is left unanswered [yes/no]. Review of R5's fall report dated 4/21/23 at 5:00AM documents at 5:00AM the CNA entered R5's room and observed R5 was falling over onto his left side. Writer observed the patient falling over the onto his left side. Post Fall investigation for the fall on 4/21/23 documents R5's root cause analysis was R5 attempting to get out of bed without assistance. Review of R5's care plan does not have a fall prevention intervention after his fall on 11/15/22. Interventions dates listed include 5/9/22; 6/23/22; and 7/7/22. R5's hospital records dated 4/21/23 impression	S9999		

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S9999	Continued From page 5 documents facial lacerations. Physical assessment documents 2cm laceration above the left eyebrow. Emergency Department (ED) Course documents laceration repair performed. 2. R2 is 83 years old with diagnosis including but not limited to Metabolic Encephalopahty, Acute Heart Failure, Dementia, Anxiety Disorders, Muscle Wasting and Atrophy, Retention of Urine, Partial Intestinal Obstruction, Alcohol Abuse with Intoxication On 5/3/23 at 12:51 PM, V4 Nurse, said if a new resident is admitted the nurse gets in report if the resident is a fall risk. V4 said if we know the resident is a fall risk, we keep the bed in the lowest position, we can implement floor mats, an alarm, and keep the call light in reach. V4 said on 4/15/23 I think R2 was cleaned by V5, CNA, because R2 had a bowel movement. V4 said I was passing medications and R2's daughter called me to say he was on the floor. V4 said when I saw R2 he was sitting on the floor next to the bed. V4 said R2 was sitting on his bottom with his legs out in front of him. V4 said R2 was confused and had an incontinent brief partially off. On 5/3/23 at 1:39 PM, V5 CNA, said I know R2 fell the first day I met him on 4/15/23. V5 said the CNA before me told me R2 was a fall risk. V5 said on the day he fell his daughter had the light on and she said R2 had to use the bathroom. V5 said the daughter stepped out of the room. V5 said I gave him the bedpan, I waited a few minutes, he said he did not have to use it. V5 said R2 sat on the bedpan for a while, then he was moving around. V5 said I asked him if he was done and he did not say anything. V5 said R2 did not have a bowel movement in the bed pan. V5 said R2 wore briefs. V5 said when he left the	S9999		

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S9999	Continued From page 6 room R2 was just lying in the bed. V5 said then I was walking down the hall and R2's daughter had returned to the room and I heard someone say R2 had fallen. V5 said when I saw R2 he had his back up against the wall by the bathroom door, the bed was in the same spot. V5 said R2 would have taken about 3 or 4 steps from the bed before he fell. V5 said R2 was sitting on the floor facing the bed. V5 said R2 didn't say anything. V5 said no one has asked me anything about R2's fall until now. V5 said R2 had bowel on the bed and floor. V5 said R2 had nothing on his feet, "he probably should have grippy socks." On 5/4/23 at 11:44 AM, V10 Fall Coordinator, said fall risk should be determined on admission. V10 said according to the Fall Risk Evaluation, the higher the number the higher the risk. V10 said a fall evaluation score of 8 or greater places the resident at risk for falls. V10 said R2 should have been closer to the nurses' station. V10 said R2's daughter was the first to see R2 on the floor. V10 said R2 was sitting by the wall and had slid out of bed. V10 said she did not ask the staff if R2 had socks or shoes on, so she was unable to answer what footwear R2 had on at the time of the fall. V10 said she was unable to determine the cause of R2's fall. V10 said the nurse and the CNA she spoke to did not mention R2 having a bowel movement. On 5/4/23 at 2:43 PM, V13 Nurse Supervisor, said if I had put an alarm on a resident, I would have documented it in the progress notes. On 5/5/23 at 1:49 PM, V22 Therapy Director, said R2 was evaluated by Occupational Therapy. V22 said R2 required extensive assistance from staff and "should absolutely have 1 person assist" for transfers.	S9999		

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S9999	Continued From page 7 On 5/11/23 at 10:54 AM, V23 Admissions Director, said prior to R2's admission she "let them know he was a fall risk resident." V23 said she was aware of R2's fall risk because it was on his referral packet. On 5/18/23 at 11:36 AM, V12 DON, said the purpose of using foot wear, like non skid, is to prevent the resident from sliding. A Nursing-Admission/Readmission should be completed before end of shift or responsible admitting nurse leaves the building. V12 said all new residents have an admission assessment completed. Progress Notes dated 4/14/23 at 10:38 PM, documents R2 received at 3:00 PM. Wife requesting bed alarm for resident, nurse supervisor notified. R2's care plan documents he is at risk for falls date initiated 4/14/23. Interventions dated 4/14/23 ensure wearing appropriate footwear when ambulating or mobilizing. No Fall Risk Evaluation dated 4/14/23 was found in the record for R2. No Nursing-Admission/Readmission was found for R2. Fall Risk Evaluation dated 4/15/23 at 12:25 PM (after his fall) for R2 notes a score of 17. R2 not continent of bowel and bladder, medications identified include but not limited to diuretic, antihypertensive, narcotics, antipsychotic. R2 has had medication changes in the last 5 days. R2 has a memory problem. R2 not able to walk and confined to a chair. Evaluation documents R2 had a fall. Fall report dated 4/15/23 at 12:25 PM, notes R2	S9999		

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S9999	Continued From page 8 noted sitting on the floor. Resident unable to give description. Predisposing factors notes ambulating without assist and toileting needs. Post Fall investigation documents Fall Risk Evaluation score is 16, R2 is at risk for falls. R2 has a history of falls, at home before admission. No root cause is listed, only facts of R2's admission and his family saw R2 on the floor. R2's hospital records dated 4/15/23 document CT Lumber spine impression nondisplaced fracture of the 8-10th rib heads. 3. R7 is 79 years old with diagnosis including but not limited to Dementia, Difficulty in Walking, Cognitive Communication Deficit, and Cerebral Infarction. R7 was admitted to the facility on 4/27/23. Cognitive Assessment dated 4/29/23 documents R7 is severely cognitively impaired. On 5/9/23 at 9:59 AM, R7 observed in bed with floor mat. R7 has no wrist band on. On 5/11/23 9:27 AM, R7 observed, floor mats and bed alarm in place. On 5/11/23 at 1:07 PM, V37 CNA, said R7 is on my assignment today. V37 said this was the first time she has been assigned to R7. V37 said R7 does not try to get up out of bed. V37 said residents at risk for falls are identified when they try to get out of bed or have weakness. V37 said she was told about the CNA binder for showers and assignments today. The surveyor asked V37 if she has a list of people at risk for falls. V37 responded she asks the nurse. On 5/11/23 at 2:32 PM, V25 RN, said she was told on 5/5/23 that R7 was on the floor. V25 said	S9999		

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S9999	Continued From page 9 when she entered the room she saw R7 sitting on the floor and R7 said her nose hurt. V25 said she had been assigned to R7 before and "she never got of bed before, I was shocked." V25 said R7 had floor mats, the bed was in the lowest position, and she was on an air mattress. V25 said "possibly she rolled out of bed." V25 said R7 was barefoot when she saw her on the floor. During a follow up interview, V25 said R7's nose was bleeding and I sent her to the hospital. On 5/16/23 at 9:57 AM, V10 Fall Coordinator, said I got a call on 5/5/23 around 7:00 PM, that R7 had fallen and they were sending her to the hospital. V10 said during her investigation she spoke with V38, Guest Services, who told V10 that as she was passing the room she saw R7 face down on her stomach on the floor. V10 said V38 told her R7 was squirming and got herself sitting when the nurse walked into the room. V10 said I spoke with V28 RN, she told me that R7 tries to get out of bed. V28 said R7 was admitted as a fall risk. V10 said the cause of R7's falls is her Dementia, impulsiveness, and R7 was trying to get out of bed. On 5/16/23 at 12:15 PM, V28 RN, said R7 goes from calm and sleeping to trying to get out of bed and she will scream. V28 said R7 "really has no purpose in trying to get out of bed, except that she is confused." V28 said before 5/5/23 we stopped getting R7 out of bed. On 5/16/23 at 1:57 PM, V29 Physical Therapy, said R7 requires assistance to get out of bed. V29 said R7 does not follow verbal cues. V29 said on therapy evaluation (4/28/23) I tried to get R7 to roll in the bed and I had to help her with her arms and legs to roll.	S9999		

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S9999	Continued From page 10 R7's Functional Status Assessment dated 4/29/23 documents R7 requires extensive assistant with bed mobility, including turning side to side on the bed. R7's fall care plan initiated on 4/27/23 denotes R7 is at risk for falls related to diagnosis including Dementia and poor safety awareness. Initial interventions do not include interventions of moving R7 closer to the nurses' station, floor mat, blue wrist band, alarm, or list at the nurses station. On 5/11/23 interventions include addition of low bed, floor mats. R7's Progress Notes dated 5/2/23 document "fall risk." R7's Progress Notes dated 5/5/23 documented by V25, Registered Nurse, reads R7 on the floor with bleeding. Order received to send R7 to hospital. Post Fall Investigation for R7 dated 5/5/23 notes fall with injury, history of fall at home. R7 went to the hospital. R7 is non-ambulatory. R7 attempted to get out of bed without assistance. The facility provided a Fall Occurrence policy revised on 5/17/22 documents the residents will be assessed for risk for falls and interventions are put in place. A fall risk assessment form will be completed by the nurse or the falls coordinator upon admission. Those identified as high risk for falls will be provided fall interventions. If a resident has fallen the resident is automatically considered as high risk for falls. The nurse may immediately start interventions to address falls in the unit, even prior to the Falls Coordinator's investigation.	S9999		

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S9999	Continued From page 11 (B) Statement of Licensure Violations (2 of 2) 300.610a) 300.1210a) 300.1210b) 300.1210d)3) 300.1850c) 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 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	S9999		

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S9999	Continued From page 12 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. Section 300.1850 Other Resident Record Requirements c) The resident's record shall include information regarding the physician's notification and response regarding any serious accident or injury, or significant change in condition, as required by Section 300.1010(h) of this Part. These requirements were not met as evidenced	S9999		

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S9999	Continued From page 13 by: Based on interview and record review the facility failed to follow the change in condition policy and immediately notify the physician of new onset of pain and abnormal radiology report. This failure affected 1 of 3 residents (R8) reviewed for notification of change. This failure resulted in an over 24 hour notification of onset of ankle pain, and resulted in over a 16 hour delay in notification and treatment of a fractured right tibia. Findings include: R8's face sheet denotes R8 had the diagnosis of orthopedic after care, displaced oblique fracture of right tibia, torus fracture of lower end of right fibula, pancytopenia, anemia, thrombocytopenia, rheumatic tricuspid insufficiency, hypertension, hypertensive heart and kidney disease, atherosclerotic heart disease, pulmonary hypertension, systemic lupus erythematous, infection and inflammatory reaction, dependence on renal dialysis, personal history of sudden cardiac arrest, endocarditis, age related osteoporosis with current pathological fracture, personal history of venous thrombosis, infection following a procedure, and pericarditis in systemic lupus. R8's MDS (minimum data set) dated 10/18/22 section C denotes BIMS scores is 15 (cognitively intact). Facility final abuse report dated 10/31/22 denotes in-part R8's name, injury of unknown origin, R8 complained of pain to right ankle. NP (Nurse Practitioner) order received to transport the resident to hospital for further evaluation. X-ray revealed an acute minimally displaced oblique fracture of right tibia and buckling fracture of distal fibula. Family and Doctor notified. R8 is	S9999		

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S9999	Continued From page 14 29-year-old female alert and oriented x3. Past medical history (PMH) osteoporosis, systemic lupus, end stage renal disease, secondary to lupus nephritis, libman-sacks endocarditis, status post bioprosthetic tricuspid valve replacement 2020, pulmonary hypertension, Pulseless Electrical Activity (PEA) cardiac arrest, chronic hypoxic respiratory failure, left atrial appendage thrombus, infection at right hip surgical site. On 10/25/22 NP saw R8 and R8 complained of pain to her right ankle. R8 did not have any fall. R8 stated that during a transfer her right foot got caught unintentionally bent when she was transferred to the chair. She (R8) did not have any pain at the time. R8 was sent to hospital for further evaluation. The Xray revealed an acute minimally displaced oblique fracture of right tibia and buckling fracture of distal fibula. R8 returned to the facility with a right lower extremity (RLE) splint and follow up appointment to ortho 11/1/22. R8's progress note dated 10/23/22 at 3:45 PM, completed by V26 (Agency Nurse) denotes in-part, C/o (complain of) right ankle pain at change of shift. Notified oncoming nurse to follow up with patient/MD (Medical Doctor). R8's progress note dated 10/24/22 at 5:59 PM, denotes in-part, new order for X-ay of right ankle received from doctor r/t (related to) pain and swelling. X-ray completed and results pending. R8's progress notes dated 10/25/22 at 11:56 AM, denotes in-part patient is going to hospital for right ankle fracture determined by Xray. Ride called in to ambulance service with last vitals posted. R8's progress note dated 10/25/22 at 10:48 PM, denotes in-part, resident returned from hospital	S9999		

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S9999	Continued From page 15 Dx (diagnosis) right ankle fracture vitals 90/76 HR (heart rate) 78, RR (respiratory rate) 19, temperature 98.1, no complaints of pain at this time resident did not return with any new orders all needs met at this time resident is currently in bed watching tv all safety measures are in place endorsed to oncoming nurse to continue to monitor. R8's Emergency Department records dated 10/25/22 denotes in-part impression and plan, acute right ankle pain, 29-year-old female with complicated medical Hx (history) as indicated in doctors note, presents with right ankle pain after ankle twisted underneath her while she was being transitioned from her wheelchair into a chair. Lateral and anterior ankle pain, limited ROM due to pain, swelling which is chronic. Xray reveals acute fracture as indicated. Ortho c/s (consult). Plan for splint, pain control, out f/u (follow up) in ortho clinic. Xray ankle 2 views; oblique minimally displaced fracture of the diaphysis of the tibia, buckling fracture distal diaphysis of the fibula. Placed posterior short leg splint, patient still with sensation intact to light touch (SILT) throughout toes of the RLE (right lower extremity), able to wiggle toes, cap refill less than 2 seconds, no numbness/tingling after splint placement. R8's post-acute skilled nursing home subsequent visit notes completed by the provider denotes patient is seen today laying in bed just back from HD (hemodialysis), says she feels well, still with RLE pain and R (right knee immobilizer in place. Patient reports an incident that occurred 4 days ago, while being transferred at dialysis her R (right) leg was bent in an unusual manner; this was reported by her mother who is concerned that she might have another fracture; patient is pointing at her ankle will obtain Xray. 10/25/22	S9999		

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S9999	Continued From page 16 denotes in-part pt (patient) (R8) c/o pain R (right) ankle to MD (medical doctor) yesterday. Per nursing pt (patient) was being moved to get into HD (hemodialysis) chair and per patient her right foot went the wrong way and since then has been having pain. Xray reviewed and shows acute distal tibial fracture. See below under labs. Pt sent to hospital for further imaging and possible ortho consult. Pt with immobilizer to R (right) knee/leg. NWB to RLE x3 months-right femoral neck fracture s/p hemiarthroplasty 7/8 and ORIF 7/17; R (right) plateau repair done around this time as well. Patient to have wound vac placed to right hip per doctor but has not placed yet and will do once patient returns. 10/27/22 denotes patient seen laying in bed. Patient went to ER for imaging shows fractures of distal tibia and fibula. Returned with splint to RLE (right lower extremity) and has a f/u (follow up) with ortho 11/1. Scheduler changed from 10/31 since that is a HD day. Patient with pain per therapy and not using norco as she thought she was receiving it and didn't realize she has to ask for pain meds. Scheduled norco and script prescribed to pharmacy. Patient also with thrush and ordered nystatin. Max A (assist) for scooting in bed. Pain limiting her progress. Scheduled norco. On 5/24/23 at 5:59 PM, V26 (Agency Nurse) said she documented the progress note for 10/23/22 when R8 had complaints of right ankle pain, V26 said her shift (7am-330 pm) was ending and she endorsed to the oncoming nurse to notify the physician. V26 said she does not remember giving R8 anything for pain, V26 said does not remember asking R8 about what happened to her ankle. V26 describe the nurse as tall, lighter skin female. V26 said she does not know the name of the nurse that she endorsed to.	S9999		

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S9999	Continued From page 17 On 5/24/23 at 5:24 PM, V52 (Agency Nurse) said she was the nurse that sent R8 out to the hospital on 10/25/22. V52 said she remembers R8 telling her that staff inadvertently hit her foot or leg during a transfer, and that R8 mentioned it happened days ago. V52 said she talked to the medics when they picked R8 up for transport, R8 medic report reviewed with V52, V52 said yes that was her statement to the medics. V52 said V6 (Restorative Nurse) informed her that R8's X-ray showed a fracture and that R8 needed to go to the hospital. R8's radiology exam report with exam date 10/24/22 at 7:24 PM, reported date 10/24/22 7:25 PM denotes in-part right ankle X-ray, findings- there is an acute displaced fracture at the distal tibia, no dislocated or subluxation. No osteoblastic or osteolytic lesion noted, the other visualized structure appears osteoporotic. Impression un-displaced fracture at the distal tibia. Review of R8's progress notes there is no documentation that the physician was notified on the next shift 3-11:30 PM, there is no documentation that an assessment of R8's right ankle was conducted by the nurse, there is no documentation that the physician was notified on the 11:00 PM-730 AM shift. R8 progress notes dated 10/24/23 at 5:59 PM denotes new orders for Xray of right ankle received from doctor related to pain and swelling. R8's Physician Order Sheet (POS) dated 10/24/22 documents X-ray right ankle for pain. On 5/24/23 at 6:30 PM, V12 (Director of Nursing) said the physician should be notified of the residents' complaints of pain/ change in condition	S9999		

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S9999	Continued From page 18 before the nurse leave their shift. V12 said the nurse should conduct and assessment, gather information, and notify the physician of the assessment findings and resident complaints of pain. V12 said the nurse should notify the physician for further directives. R8's progress notes reviewed with V12, V12 was asked if there was documentation that the physician was notified of R8's complaints of pain, and documentation that the nurse conducted an assessment, V12 said she did not find any documentation. V12 was made aware of the concern for physician notification for over 24 hours for complaint of pain, and that R8 was not sent to hospital for over 15 hours after the positive Xray results. V12 said R8 transferred with mechanical lift with 2-person physical assist. V12 said the facility did not complete an incident report for R8's fracture to the right ankle. On 5/24/23 at 6:32 PM, V50 (Consultant) said R8 had a history of multiple fractures, comorbidities, and conditions that could result in a fracture from the slightest bump. V50 was asked should the physician be notified immediately when there's a complaint of pain since R8 has a history of being at risk for fractures from a slightest bump. V50 said that's a good analogy. V50 said V42 (Medical Director) can speak to surveyor regarding R8's health history. On 5/24/23 at 12:19 PM, V42 (Medical Director) said he agrees with V50's statement that R8 could sustain a fracture from the slightest bump. V42 said R8 was not under his care, and he spoke with the provider from PAN, V42 said R8 has a history of lupus, R8 was on steroids long term, steroids can cause bone loss, R8 had kidney disease, receiving hemodialysis for end stage renal disease and R8 developed osseus	S9999		

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S9999	Continued From page 19 dystrophy which cause bone loss of patients with renal disease. V42 said R8 had a hip fracture in the past, where hardware was implanted, V42 said R8's fracture was not healing, and they physician wanted to remove the hardware but R8's bones are so thin. V42 said R8 is highly susceptible to fractures of the bones. V42 said the physician should have been notified of R8 complaints of pain if it was persistent, it did not have to be immediately, because R8 already had a fracture. V42 was informed that R8 had new complaints of pain to her ankle. V42 said he was informed by V12 (Director of Nursing) that R8 did not have any complaints of pain. R8 records reviewed with V42 denoting that R8 complained of pain on 10/24/22 to the physician, and V42 was informed that R8 complained of pain on 10/23/22 to the nurse per progress notes. V42 was asked if R8 is susceptible to fractures should the physician be made aware of R8 complaints of pain for directives. V42 said R8 received an Xray. V42 said he was not aware that R8 was not sent out to the hospital for over 15 hours after the Xray showed a fracture. R8's Xray results reviewed with V42 denoting results reported at 7:25 PM on 10/24/22. V42 then said there was no delay in care because R8 did not require treatment. V42 was informed that R8's hospital discharge summary denotes that R8 required a splint to the right ankle. V42 clarified that R8 did not require a surgical treatment. V42 said as a medical director that he would have not sent R8 out to the hospital immediately because R8 did not have pain, V42 said it would have been a burden to R8. R8 progress note reviewed with V42, denoting R8 had complaints of pain, R8 and her family was concerned that there may be another fracture. V42 was asked how this could be a burden for R8 when R8 had complaints of pain, and concerns for new fracture. V42 said R8 already had a brace	S9999		

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in place. R8 records reviewed and V42 was informed that R8's brace was for the right knee and not the ankle. V42 clarified that he was not R8's physician. V42 said the physician should have been notified of R8 complaints of pain and the physician should have been notified of the Xray results showing a fracture. V42 said he was just saying there was no harm to R8 because of the physician not being notified. V42 was made aware that the facility is surveyed for the care and safety of the residents, and that R8's Xray was not ordered for over 24 hours after complaints of pain, and R8 was not sent to the hospital for over 15 hours after the positive X-ray results. V42 said the care and safety of the residents are his concerns also.

On 5/24/23 at 2:24 PM, V51 (radiology company personnel) said the radiology company was notified at 18:02 (6:02 PM) of request for Xray, V51 said the tech was notified at 18:10 (6:10 PM), V51 said the facility was notified of the X-ray results at 19:25 (7:25 PM), V51 said the results are uploaded to the electronic medical records after completion for the facility to view. V51 said the results are reviewed by the physician and uploaded to the electronic records. V51 said the process is the radiology company should call the facility and inform the facility of the positive results. V51 said the radiology company did not contact the facility and speak to someone and inform the facility of the positive results. V51 said the results were reported to the facility when the results were uploaded to the electronic records.

On 5/24/23 at 1:00 PM, request made to review facility radiology contract; facility failed to present radiology contract for review during this survey.

Facility Policy titled change in condition with last

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S9999	Continued From page 21 revision date of 7/28/22 denotes in-part the facility will provide care to residents and provide notification of residents change in condition status. The facility must immediately inform the residents; consult with the resident's physician; and if known, notify the residents legal representative, or an interested family member when there is a significant change in in the resident physical, mental or psychosocial status, a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility. Per federal definition a need to alter treatment significantly means a need to stop a form of treatment because of adverse consequences or commence a new form of treatment to deal with a problem (the use of any medical procedures, or therapy that has not been used on that resident before). (B)	S9999		