STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009948	A. BUILDING: _____ B. WING _____	C 06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITY VIEW MULTICARE CENTER	5825 WEST CERMAK ROAD CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Investigation of Facility Reported Incident of 01-27-2023/IL157592 Investigation of Facility Reported Incident of 04-11-2023/IL158659 Investigation of Facility Reported Incident of 04-10-2023/IL159608 Complaint Investigations: 2392228/IL157656 2392512/IL158006 2392875/IL158437 2393317/IL158956 2393443/IL159081 2393951/IL159762 2393692/IL159434 2394268/IL160158	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 4: 300.610a) 300.1010h) 300.1210b) 300.1210d)3)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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 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	S9999		

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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.

These Regulations are not met as evidenced by:

Based on interviews and record reviews, the facility failed to determine the cause of one resident's major injury of unknown origin. This affected 1 of 3 (R3) reviewed for injury of unknown origin. This failure resulted in R3 complaining of left hip pain, subsequently resulting in an acute displaced fracture of the proximal left femur with superior displacement. R3 was sent to the local hospital and treated for hemiarthroplasty. The facility also failed to prevent resident to resident physical assault. This affected 4 of 6 residents (R5-R8). reviewed for physical abuse. This failure resulted in R7 being punched in the face by R8 multiple time and R7 sustaining superficial abrasions to the left temporal area and an abrasion to right upper eye. This failure also resulted in R5 being punched in the face by R6 and sustaining a laceration under the left eyebrow.

Findings Include:

Facility reported incident, initial report dated 1/27/23 reads in part: R3 observed with pain to the left hip and knee. X-ray ordered and revealed abnormalities. Physician notified with order to send to emergency room for further evaluation and treatment.

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Final incident report reads in part: R3 had a fall on 1/5/23 which an X-ray was ordered that had no abnormal findings other than osteopenia. R3 was ambulating without difficulty until 1/25/23 when R3 appeared to have difficulty with ambulation at which time PCP ordered x-ray of the hip and it was noted there was a fracture of the hip, and R3 was sent to emergency room for conclusive diagnosis. R3 admitted in the hospital with diagnosis of hip fracture. R3 has many co morbidities which place R3 at risk for fracture and the fact that the X-ray indicated osteopenia, R3's normal daily activities and weakened bones could have resulted in the fracture.

Hospital record reviewed with arrival date of 1/26/23, documented: There is no report of fall or any other trauma. Physical exam: pain with ROM (Range of Motion) left hip. R3 presents with left hip pain and was found to have a fracture. Despite the fact that there is no report of trauma a workup for possible fall is indicated as there is no clear etiology of the fracture.

Hospital record with admit date 1/27/23 documented that Ortho and ID on consult for further evaluation and treatment. Surgery tomorrow 7am, left hip hemiarthroplasty.

On 5/19/23 at 2pm, V23 (Nurse) stated that R3 was observed able to ambulate without difficulty after the fall on 1/5/23.

On 5/19/23 at 11am, V2 (Director of Nursing) stated that they investigated R3's injury of unknown origin and reported it to IDPH (Illinois Department of Public Health). V2 stated that the facility concluded that R3's fracture is due to diagnosis of osteopenia, this is a fracture caused

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by the osteopenia diagnosis and weakened bone. R3 had a fall on 1/5/23 and nothing else after that. There is no fall incident reported to me by any staff for R3. R3's complaint of pain to left leg on 1/25/23. On 1/25/23, R3 walked into another resident's room and the staff found R3 standing in the room, the staff was about to escort R3 out of that room, R3 stated "pain, pain" pointing at her leg. Staff did not report any fall incident for R3. Nurse received order for X-ray to be done in the facility. X-ray result received and it showed left hip fracture. R3 was sent to hospital for further evaluation. R3 was admitted for left hip fracture and had left hip surgery.
On 5/24/23 at 11am, V55 (Ortho Medical Assistant) stated that "For anyone with such fracture like R3 had, would most likely have difficulty walking and might have severe discomfort. They may not be able to bear weight on that leg due to discomfort. The fact that R3 came in the hospital and was scheduled for a hip surgery, it is something that needed to be corrected at that time. Any residents with this kind of hip fracture can still ambulate with sever discomfort and difficulty. V55 stated it was very unlikely for R3 to walk long because of the pain due to left hip fracture. This kind of fracture comes from a trauma such as a fall incident. V55 stated an osteopenia diagnosis alone would not just cause a hip fracture, it needed an underlying medical condition such as bone cancer for example".

R3's record reviewed and the only fall incident documented was dated 1/5/23.

Facility provided a January 2023 fall incident list and R3 had a fall on 1/5/23, one fall incident for R3 for the month of January 2023.

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S9999	Continued From page 5 Facility policy for Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Property dated 2/1/2022 reads on part: The purpose is to assure that the facility is doing all that is within their control to reduce the risk of occurrences of abuse, exploitation, misappropriation of property, mistreatment, or neglect. Identify events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse, and to determine the direction of the investigation. Investigate different types of incidents. R7 was admitted to the facility on 9/14/21 with a diagnosis of schizophrenia, asthma, seizures, post-traumatic stress disorder, hypertension, delusional disorders, and weakness. R7's BIMS dated 4/4/23 documents a score of 14/15 which indicates cognitively intact. R7's progress notes dated 4/11/23 documents: Report given from DON that resident received physical aggression while in the elevator; resident states peer threw a cup that almost hit her while in the elevator and hopped out of his wheelchair and hit her in the face; Both residents were immediately separated, head to toe assessment performed, resident noted with small laceration to left side forehead and swelling to right eye, bleeding controlled, ice pack applied, and vital signs within normal limits. The resident denied any pain or discomfort. R7's change in condition form dated 4/11/23 documents: physical aggression received. Under skin status evaluation laceration. On 5/18/23 at 11:09am, R7 who was alert and oriented stated she and R8 were on the 2nd floor entering onto the elevator at the same time which	S9999		

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resulted in a verbal exchange. R7 stated R8 threw a cup of water at her and then stood up from his wheelchair while they were on the elevator. R7 stated she thought R8 was going to hit her, so she put her foot up to him to block him. R8 then started punching R7 in the face and staff eventually separated them. R7 stated she was bleeding from her head and went to the hospital. On 5/23/23 at 3:45pm, R7 who was alert and oriented relayed the same events about the incident.

On 5/24/23 at 9:37AM, V50 (escort) stated she was waiting for the elevator on the 1st floor when the elevator doors opened, she observed R8 punching R7. R7 was not fighting back and was trying to get off the elevator.

R7's hospital records dated 4/11/23 documents: Resident presents to emergency room after altercation with another nursing home resident. Patient was hit in the face multiple times on the left side of her head and to her right eye. She shows superficial abrasion to left temporal area and an abrasion to the right upper eye.

R8's change in condition evaluation dated 4/11/23 documents under behavioral status: physical aggression; patient punched another residents in the head. Under pain documents: pain in right hand that was used to punch resident. No injuries seen.

R8's height dated 3/20/23 documents 75.0 inches and weight dated 4/18/23 304 pounds.

Facility reportable dated 4/17/23 documents: On 4/11/23 facility investigated an allegation of a peer-to peer incident between R8 and R7. R8 was interviewed and reported that he and R7

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were trying to enter the elevator at the same time which caused a disagreement about who should first enter the elevator. Per R8, he and R7 finally entered the elevator, and as the elevator was moving, R7 attempted to make physical contact with him by raising her leg up towards his waste, he then attempted to block her and she started flailing her arms towards his face, and he started flailing his arms and hands back at her towards her face, he and R7 then made physical contact as the elevator door opened on the first floor. Staff then entered the elevator and separated he and R7. R8 was escorted to his floor and assessed by the Nurse. R8 was noted with pain to his left hand with no visible injuries and no skin discolorations.

R7 was interviewed and reported that she was attempting to enter the elevator and R8 was trying to get on the same time and a disagreement ensued between them. After they entered the elevator, R8 started swinging his arms in a flailing motion and she started flailing her arms, and they both made physical contact on the elevator. Once the elevator arrived at the 1st floor, a staff member intervened and separated them. R7 was escorted to her room and assessed by the nurse. R7 was noted with swelling of the right eyelid and discoloration of the right eyelid, and some bruising to the left side of head.

Facility abuse policy dated 2/1/22 documents: The purpose is to assure that the facility is doing all that is within their control to reduce the risk of occurrences of abuse, mistreatment, and neglect. Abuse is the willful infliction of injury, intimidation or punishment with resulting physical harm, pain, or mental anguish. Physical abuse includes hitting, slapping, pinching, pulling, and kicking.

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R5 was admitted to the facility on 7/19/22 with diagnoses of parkinson's, schizoaffective disorder, dementia, weakness, lack of coordination, hypothyroidism, and dehydration.

On 5/19/23 at 12:55PM, V23 (Nurse) stated she saw R5 in the hallway with a cut to his face. V23 stated she spoke to R6 at that time who admitted to hitting R5. V23 stated R6 said R5 did not hit him back.

R5's progress note dated 4/10/23 documents: R5 has a small laceration under left eyebrow. First aide done.

Facility abuse reportable dated 4/10/23 documents: R6 reported that R5 entered his room rummaging through his belongings R6 stated R6 attempted to redirect R5. Per R6, R5 did not respond, so he approached R5 to escort him away from his belongings and R5 put his arms up in flailing motion. R6 then put up his arms to redirect R5s arms and that is when he and R5 made physical contact. R5 had a small opening under his left eye.

Facility abuse policy dated 2/1/22 documents: The purpose is to assure that the facility is doing all that is within their control to reduce the risk of occurrences of abuse, mistreatment, and neglect. Abuse is the willful infliction of injury, intimidation or punishment with resulting physical harm, pain, or mental anguish. Physical abuse includes hitting, slapping, pinching, pulling, and kicking.

R7 was admitted to the facility on 9/14/21 with a diagnosis of schizophrenia, asthma, seizures, post-traumatic stress disorder, hypertension, delusional disorders, and weakness. R7's BIMS dated 4/4/23 documents a score of 14/15 which

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S9999	Continued From page 9 indicated cognitively intact. R7's progress notes dated 4/11/23 documents: Report given from DON that resident received physical aggression while in the elevator; Resident states peer threw a cup that almost hit her while in the elevator and hopped out of his wheelchair and hit her in the face; Both residents were immediately separated, head to toe assessment performed, resident noted with small laceration to left side forehead and swelling to right eye, bleeding controlled, ice pack applied, and vital signs within normal limits. The resident denied any pain or discomfort. R7's change in condition form dated 4/11/23 documents: physical aggression received. Under skin status evaluation laceration. On 5/18/23 at 11:09am, R7 who was alert and oriented stated she and R8 were on the 2nd floor entering onto the elevator at the same time which resulted in a verbal exchange. R7 stated R8 threw a cup of water at her and then stood up from his wheelchair while they were on the elevator. R7 stated she thought R8 was going to hit her, so she put her foot up to him to block him. R8 then started punching R7 in the face and staff eventually separated them. R7 stated she was bleeding from her head and went to the hospital. On 5/23/23 at 3:45pm, R7 who was alert and oriented relayed the same events about the incident. On 5/24/23 at 9:37am, V50 (escort) stated she was waiting for the elevator on the 1st floor when the elevator doors opened, she observed R8 punching R7. R7 was not fighting back and was trying to get off the elevator. R7's hospital records dated 4/11/23 documents:	S9999		

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S9999	Continued From page 10 Resident presents to emergency room after altercation with another nursing home resident. Patient was hit in the face multiple times on the left side of her head and to her right eye. She shows superficial abrasion to left temporal area and an abrasion to the right upper eye. R8's change in condition evaluation dated 4/11/23 documents under behavioral status: physical aggression; patient punched another resident in the head. Under pain documents: pain in right hand that was used to punch resident. No injuries seen. R8's height dated 3/20/23 documents 75.0 inches and weight dated 4/18/23 304 pounds. Facility reportable dated 4/17/23 documents: On 4.11.23 facility investigated an allegation of a peer-to peer incident between R8 and R7. R8 was interviewed and reported that he and R7 were trying to enter the elevator at the same time which caused a disagreement about who should first enter the elevator. Per R8, he and R7 finally entered the elevator, and as the elevator was moving, R7 attempted to make physical contact with him by raising her leg up towards his waist, he then attempted to block her and she started flailing her arms towards his face, and he started flailing his arms and hands back at her towards her face, he and R7 then made physical contact as the elevator door opened on the 1st floor. Staff then entered the elevator and separated he and R7. R8 was escorted to his floor and assessed by the Nurse. R8 was noted with pain to his left hand with no visible injuries and no skin discolorations. R7 was interviewed. R7 reported that she was attempting to enter the elevator and R8 was trying to get on the same time and a disagreement ensued between them. After they entered the elevator, R8 started swinging his	S9999		

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arms in a flailing motion and she started flailing her arms, and they both made physical contact on the elevator. Once the elevator arrived at the first floor, a staff member intervened and separated them. R7 was escorted to her room and assessed by the nurse. R7 was noted with swelling of the right eyelid and discoloration of the right eyelid, and some bruising to the left side of head.

Facility abuse policy dated 2/1/22 documents: The purpose is to assure that the facility is doing all that is within their control to reduce the risk of occurrences of abuse, mistreatment, and neglect. Abuse is the willful infliction of injury, intimidation or punishment with resulting physical harm, pain, or mental anguish. Physical abuse includes hitting, slapping, pinching, pulling, and kicking.

R5 was admitted to the facility on 7/19/22 with a diagnosis of parkinson's, schizoaffective disorder, dementia, weakness, lack of coordination, hypothyroidism, and dehydration.
On 5/19/23 at 12:55PM, V23(Nurse) stated she saw R5 in the hallway with a cut to his face. V23 said she spoke to R6 at that time who admitted to hitting R5. V23 stated R6 said R5 did not hit him back.

R5's progress note dated 4/10/23 documents: R5 has a small laceration under left eyebrow. First aide done.

Facility abuse reportable dated 4/10/23 documents: R6 reported that R5 entered his room rummaging through his belonging and attempted to redirect R5. Per R6, R5 did not respond, so he approached R5 to escort him away from his belonging and R5 put his arms up in flailing motion. R6 then put up his arms to redirect R5s

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arms and that is when he and R5 made physical contact. R5 had a small opening under his left eye.

Facility abuse policy dated 2/1/22 documents: The purpose is to assure that the facility is doing all that is within their control to reduce the risk of occurrences of abuse, mistreatment, and neglect. Abuse is the willful infliction of injury, intimidation or punishment with resulting physical harm, pain, or mental anguish. Physical abuse includes hitting, slapping, pinching, pulling, and kicking.

(A)

Statement of Licensure Violations 2 of 4:
300.610a)
300.1010h)
300.1210b)3)
300.1210c)
300.1210d)2)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 300.1010 Medical Care Policies

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CITY VIEW MULTICARE CENTER	5825 WEST CERMAK ROAD CICERO, IL 60804

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S9999	Continued From page 13 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 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. Restorative measures shall include, at a minimum, the following procedures: 3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. c) Each direct care-giving staff shall review	S9999		

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S9999	Continued From page 14 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: 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. 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 Regulations are not met as evidenced by: Based on observations, interviews and record reviews, this facility failed to consistently monitor and implement pressure relieving interventions to promote healing and prevent a community acquired wound from worsening. This affected 1 of 4 residents (R11) reviewed for pressure sore prevention protocols. This failure resulted in R11's preexisting stage 3 wound worsening into a	S9999		

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S9999	Continued From page 15 preventable stage 4. Findings include: On 5/18/23 at 11:15am, R11 was observed to have a low air loss mattress with setting for 360-pound resident. R11 was observed to have bilateral heel protectors on. The inside of these boots was covered with dry flakes of skin and several quarter size spots of dried brown substance. On 5/18/23 at 11:40am, this surveyor observed V31 perform wound care treatment for R11. R11 was observed to have a stage 4 right ischium (buttock) pressure ulcer. Wound measured 4cm (centimeters) x 0.7cm x 0.3cm. Wound with 90% granulation tissue and 10% slough (yellow tissue). V31 cleaned R11's wound with wound cleanser, packed wound with calcium alginate and then covered wound with a dry dressing. On 5/18/23 at 12:35pm, this surveyor observed V27 CNA and V33 CNA provide care to R11. R11 was observed to have a large soft bowel movement. The proximal and medial sides of right ischium dressing were observed to be not adhering to R11's skin and bowel movement was observed on the inside and the outside of R11's dressing. On 5/18/23 at 4:05pm, this surveyor observed the CNA remove R11's incontinence brief. R11's right ischium dressing appears to be the same dressing as at 12:35pm. There is dried bowel movement on dressing. The proximal and medial sides of dressing are rolled under dressing and touching R11's wound. On 5/18/23 at 11:15am, R11 stated that R11's	S9999		

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S9999	Continued From page 16 wound dressings are changed every Monday, Wednesday, and Friday by V31. R11 stated that V31 was not present in the facility yesterday so his dressings were not changed until this morning. R11 stated that he gets out of bed once in a blue moon. R11 does not recall the last time he got out of bed. R11 stated that R11 weighs 180 pounds. On 5/18/23 at 12:00pm, when questioned does having the mattress setting on 360 pounds affect R11's wounds, V3 DON replied there would be a decline in wound or R11 could develop new pressure ulcer. On 5/18/23 at 12:00pm, V31 stated that staff bump into the knob that controls the weight setting for the air mattress causing the setting to change. V31 was observed pushing R11's nightstand into the controls on the air mattress. This surveyor observed the weight control knob did not move. On 5/18/23 at 12:45pm, V33 CNA stated that residents should receive incontinence care every two hours and as needed. V33 stated that if a resident has a dressing that becomes soiled during care, the nurse should be notified to change the resident's dressing. On 5/19/23 at 9:40am, V31 stated that all wound care treatments are documented in the resident's TAR (treatment administration record). V31 stated that the nurse should change the dressing if it becomes soiled. On 5/19/23 at 11:15am, V3 DON stated that all wound care orders have orders for scheduled and as needed dressing changes. V3 stated that the nurse is expected to change the resident's	S9999		

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dressing(s) when soiled. V3 stated that all dressing changes are documented on the resident's TAR.

On 5/23/23 at 2:30pm, V22 RN stated that V22 was assigned to R11 yesterday and today. V22 stated that R11's dressings are changed every Monday-Wednesday-Friday by V31. V22 stated that R11's dressings were changed yesterday by V31. V22 stated that the CNA is expected to notify the nurse if a resident's dressing falls off or is soiled. V22 stated that V31 will do as needed dressing changes for soiled dressings if V31 is not present at the facility, otherwise the floor nurse will do dressing change. V22 stated that the CNA did not inform her that R11's dressing needed to be changed today.

Review of R11's medical record notes R11 was admitted to this facility on 2/4/23 with diagnoses including paraplegia, peripheral autonomic neuropathy, chronic indwelling catheter, heart failure, chronic obstructive pulmonary disease, and anemia. R11 was transferred from this facility to the hospital on 2/4/23. R11 was re-admitted to this facility on 2/15/23.

Review of R11's transfer medical record, dated 2/2/23, R11 had a facility acquired stage 3 right hip pressure ulcer. R11's wound was 10% deep maroon tissue and 90% bright pink/red tissue, periwound with redness and maceration. R11's wound measured 3.5cm (centimeters) x 1.5cm x 4.5cm.

Review of R11's wound care documentation, dated 2/22/23, notes R11 with a right hip stage 3 pressure ulcer measuring 4.7cm x 1.6cm x 1cm.

R11's wound care documentation, dated 4/11/23,

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notes R11 with a stage 4 right hip pressure ulcer, measuring 2.5cm x 0.3cm x 0.1cm.

R11's wound care documentation, dated 5/1/23, notes R11's stage 4 right hip pressure ulcer measures 3cm x 0.6cm x 0.3cm.

R11's wound care documentation, dated 5/15/23, notes R11's stage 4 right hip pressure ulcer measures 3.5cm x 1cm x 0.3cm.

Review of R11's POS, dated 2/16/23, notes an order to apply calcium alginate to right ischium (buttock) cover with a foam dressing daily and as needed after wound cleansed with normal saline or wound cleanser. This order was discontinued on 4/10/23.
Review of R11's MAR (medication administration record) notes the following:
February 2023, R11's dressing was changed on the 2/27.
March 2023, R11's dressing was changed on 3/3 and 3/17.
April 2023, there is no documentation noting R11's dressing was changed.

Review of R11's POS, dated 4/12/23, notes an order to apply hydrocolloid dressing to right ischium (buttock) every Monday-Wednesday-Friday and as needed after cleansing wound with normal saline or wound cleanser.

Review of R11's MAR notes the following:
April 2023, R11's dressing was changed on 4/26 and 4/28.
May 2023, R11's dressing was changed on 5/1, 5/3, 5/5, 5/8, 5/10, 5/17, 5/22, and 5/24.

There is no documentation found in R11's

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S9999	Continued From page 19 medical records noting R11 received all scheduled wound care treatments for February, March, April, and May. Review of R11's alteration in skin integrity care plan, dated 2/27/23, notes R11 is at risk for additional and/or worsening of skin integrity related to incontinence of bowel. Intervention identified includes to administer wound care treatments per physician orders. Review of this facility's treatment/services/heal pressure and non-pressure wounds policy, dated 11/2/2022, notes a resident with pressure ulcers will receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new wounds from developing. (B) Statement of Licensure Violations 3 of 4: 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy 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	S9999		

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S9999	Continued From page 20 and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Regulations are not met as evidenced by: Based on interview and record review, the facility failed to prevent and deescalate a verbal altercation from becoming physical to prevent an avoidable accident. This failure affected 2 of 3 residents (R1, R28) reviewed for supervision of behaviors. The facility also failed to implement effective fall prevention interventions to prevent or reduce the risk of falling. This failure affected 2 of 3 (R14, R24) residents reviewed for fall prevention. This failure resulted in R1 standing up from his wheelchair taking a swing at R28. R1	S9999		

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S9999	Continued From page 21 lost his balance and fell to the floor sustaining a right hip dislocation. Findings include: On 5-25-23 at 9:30am, R1 (via translator) stated at 3:00am, two residents opened his door and was looking into his room. R1 was able to identify R28 and the other resident was not identified. R1 stated he shouted at the residents and the residents closed the door and went away. At 9:00am, during R1's smoke break on the 2nd floor, R1 stated he saw R28, and he warned R28 not to go to his room. R1 stated R1 and R28 were yelling at each other. R1 stated he did not want to fight R28, and the staff had to separate R1 and R28. R1 stated he went upstairs to the 4th floor. R1 stated around 9:30am, R1 was in the day room receiving his medications and R28 confronted R1. R1 stated the other resident instigated a fight with R1. R1 stated he stood up to swing at the other resident, lost his balance, and fell on his side. R1 stated he had pain to his right hip and told the nurse. R1 is deaf however is able to communicate by reading lips. On 5-25-23 at 12:09pm, V2 state R1 and R28 had an altercation. V2 stated V2 was informed R1 and R28 had a peer-to-peer altercation. V2 stated this occurred in the 2nd floor smoke room V2 and PRSA (psychiatric rehabilitation service aide) separated R1 and R28. R28 reported R1 was making comments against R28. R1 and R28 were having a verbal disagreement then R28 reported R1 grabbed him. V2 stated the PRSA intervened and separated R1 and R28. On 5-26-23 at 9:54am, V2 stated cannot substantiate abuse. R1 mentioned R28 was coming to his room. No staff was aware of R28	S9999		

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going to his room. R28 was making inappropriate comments to R1. R1 and R28 made physical contact. They grabbed each other. R1 and R28 have psych diagnoses. The PRSA separated R1 and R28. R1 reported he stood up in his room and sat back down. R1 reported standing in smoke room during altercation, lost balance, and fell back into his wheelchair. V2 state R1 is noncompliant with his non-weight bearing status. R1 admitted he stood up on his own.

On 5-25-23 at 2:38pm, V3 (DON) stated R1 is alert, oriented x3-4, and able to make his needs known. V3 stated she is not aware of any aggressive behaviors previous to the current incident with R28. V3 is not aware of R1 and R28 having any issues. V3 (DON) stated R28 is alert, oriented x3, and able to make his needs known. V3 is not aware of R28 having any aggressive behaviors towards resident or staff or R1. V3 stated she was informed R1 and R28 had a disagreement and R1 was complaining of hip pain after a recent hip resection. R1 was sent out and diagnosed with a hip dislocation (same affected side). V3 stated she is not aware of the incident.

On 5-25-23 at 1:03pm, V59 (RN) stated V59 was the primary nurse for both R1 and R28 during AM shift. V59 stated R28 is alert oriented x2-3 and able to make his needs known. V59 stated she was on the unit while R1 and R28 were in the 2nd floor smoking room. R28 told V59 R1 was kicking and cursing at R28. V59 stated R28 has history of aggressive behavior when it comes to smoking. V59 stated R1 is alert oriented x3 and able to make needs known. R1 has history of physical and verbal aggression towards his peers. V59 stated R1 stated R28 was kicking and cursing at R1. R1 told V59 and Activity Director R1 grabbed

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R28 because he was being made fun of. V59 stated R1 and R28 were tussling. V59 stated R28 can walk and R1 can stand up. V59 stated no staff reported R1 or R28 falling to the floor. V59 stated R1 complained of unbearable pain to right hip and rated pain 9 out of 10 and recent hip arthroplasty. V59 sent R1 out to hospital and hospital found right hip dislocation. V59 stated R28 tried to attack R1 but security stopped the attack on the 4th floor. V59 stated no physical contact occurred on the 4th floor. V59 stated security removed R28.

On 5-25-23 at 1:16pm, V24 (social services) stated R1 is alert oriented x4, able to make his needs known. R1 has history of physical and verbal aggression towards peers. V24 is not aware of R1 and R28 having previous altercation or incidents. V24 stated R28 is alert, oriented x2-3 (fluctuates) and able to make his needs known. V24 stated R28 has history of verbal aggression. V24 stated R1 stated something R28 didn't like, and this led to a physical fight. V24 stated R28 could not recall what R1 stated to him, and this occurred in the 2nd floor smoke room.

On 5-25-23 at 2:07pm, V18 (PRSA) stated R1 is alert oriented and able to make his needs known. V18 stated R28 is alert, oriented, and able to make his needs known. V18 is aware of R28 having verbal aggression towards smoking monitors. V18 stated V18 had to remove R28 from the smoking area due to his aggressive behaviors (in the past) however, V18 is not aware of any physical aggression towards staff. V18 stated he was present on the 2nd floor and heard commotion. V18 saw R1 and R28 holding each other in an aggressive manner. R1 and R28 were bear hugging each other. R1 and R28 were standing on their feet. V18 stated he did not see

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R1 or R28 have any fall or injury. V18 split R1 and R28 immediately. V18 stated he instructed R28 to sit down while V18 escorted R1 to the 4th floor. V18 informed the nurse that R1 was in an altercation and V18 went back down to the 2nd floor. V18 went to R28 and removed him from the smoking floor and escorted him to the elevator. V18 is not aware of what floor R28 went to because V18 had a meeting to attend. V18 stated he is not aware of any further altercation between R1 and R28.

Progress note dated 5/22/23 documents: Informed by staff resident was involved in physical aggression with peer R1 in smokeroom on second floor. When asked what happened the resident stated, " he was bothering me, calling me out of my name disrespecting me, so I grabbed him". Resident immediately separated, assisted to assigned unit. No new injuries/bruising noted from event. Resident complained of right hip pain 9 out of 10 given prn (as needed) pain medication, tolerated well. Resident assisted to bedroom, management informed, administration informed, police department aware report completed, MD aware, send resident to Hospital for medical evaluation at this time.

Progress note dated 5/22/23 documents: Informed by staff resident was involved in physical aggression with peer R28 in the smokeroom on second floor. When asked what happened the resident stated, " he was talking to me in any kind of way, so I talk to him the same way and he grabbed me". Resident immediately separated, assisted to assigned unit. No new injuries/bruising noted from event. Resident denies any complaints of pain/discomfort at this time. Resident assisted to bedroom,

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management informed, administration informed, police department aware report completed, MD aware, responsible for self. Resident has in-house transfer to room transfer at this time.

R1's Hospital Record dated 5-22-23 documents: History of Present Illness: Initial Comments: 49-year-old male sent from nursing home for right hip pain. He was in an altercation and felt a sudden pain and can't stand due to right hip pain. He denies any other injuries. Denies head injury or loss of consciousness. Physical Exam: Extremities: right leg held in flexion, internal rotation, and shortened. Progress Notes: This patient presents with a right hip dislocation approximately one month after right hip replacement. No other injuries reported. Radiology Impressions: Impression: Redemonstration of a right total hip arthroplasty with overlying skin staples consistent with recent surgery. Soft tissue air has improved since prior. However, there is now a complete right hip dislocation. Primary Impression: Hip dislocation, right.

Initial Reportable dated 5-22-23 documents: Brief Description of Incident: Facility received report that resident R1 and resident R28 was involved in a peer-to-peer incident. Immediate Action Taken: Residents were separated by staff and placed on monitoring. Both residents were assessed by nursing staff with no visible injuries or skin discolorations. Facility initiated an investigation. Police Department notified, and both residents MD was notified. Final Reportable was not completed at the time this was written.

R14 has diagnoses of rhabdomyolysis and lack of coordination. R14's MDS section C (cognitive patterns) dated 12/15/22 documents a score of

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fifteen which indicates cognitive intact. Section G (functional status) documents: R14 requires extensive assistance with toileting with one-person physical assist. Moving from seated to standing position, on and off toilet-not steady, only able to stabilize with staff assistance. R14 also requires limited assistance with transfers with one-person physical assist. Fall event report dated 3/11/23 documents: Resident (R14) was observed with walking difficulty while getting his medication. R14 states he fell the other day unwitnessed. Mobility: Ambulatory without staff assistance.

On 5/19/23 at 1:39pm, V21 (nurse) stated, R14 walked to the nursing station limping. R14 reported he had a fall the night before. R14 complained of lower back, bilateral knee pain and the middle of R14's nose was swollen. R14 reported he fell on his face. R14 had an unwitnessed fall.

On 5/19/23 at 2:54pm, R19 (R14's roommate) who was assessed to be alert and orient to person, place and time, stated, R14 slipped and fell on some water by the bathroom. R14 laid on the floor for hours. R14 had a bloody nose. I helped clean R14's blood up with paper towels. R14's nose was swollen. R14 complained of back and leg pain. I helped R14 up off the floor. I went to get help, but the nurse and security tech were sleep. I did not disturb them. No CNA was available.

On 5/23/23 at 11:42am, R14 who was assessed to be alert and orient to person, place and time, stated, I went to the bathroom, slipped on some water and fell face down on the floor around 2:00am on 3/10/23. R19 tried to help me up but I fell again hitting the back of my head. My nose

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was bleeding a lot, I had two black eyes. I damaged my spinal cord. I hurt my back and leg. R19 was finally able to help me off the floor to my bed. I stayed in bed for the rest of the night/early morning due to the pain. I reported the incident to the nurse the next morning. I'm currently in a wheelchair. I can't walk. No staff was available to help. Staff on my floor usually sleep around 2am-3am. I had a clock in my room.

Nursing note dated 3/11/23 documents: at approximately 6:00am resident (R14) observed walking with difficulty, resident complaint pain on his back and states that he fell the other day unwitnessed.

Hospital paperwork dated 3/11/23 documents: Patient (R14) presented with blunt head trauma after a mechanical trip and fall with complaints of sacral back pain. R14 was diagnosed with subarachnoid hematoma within the medial aspect of the right frontal lobe and a nasal bone fracture and a small occipital scalp hematoma.

Fall policy dated 8/2017 did not apply

R24 was diagnosed with schizoaffective disorder, lack of coordination, difficult in walking, extrapyramidal and movement disorder and repeated falls. R24's MDS section C (cognitive pattern) dated 1/18/23 documents: cognitive skill for daily decision-making documents moderately impaired. Section G (functional status) dated 5/8/23 documents: R24 requires extensive assistance with one-person physical assist with bed mobility, transfers, walk in room/corridor, locomotion on/off unit and toilet use. Balance during transition and walking (moving from seated to standing, walking, turning around, moving on/off toilet and surface to surface

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transfer) not steady, only able to be stabilized with staff assistance. R24's BIMS dated 5/25/23 documents a score of five which indicates severe cognitive impairment. Fall risk review dated 2/11/23 documents: gait/balance requires use of assistive device- Conclusion: A score of ten or above represent high risk. R24 had a total score twelve. R24's Care plan initiated 12/06/22 documents: R24 is non-complaint with interventions put in place to reduce the risk of injury and falls as evidence by removing helmet not using wheelchair refusing to let staff assist. Intervention-staff to anticipate and meet R24's needs

Fall event dated 4/5/23 documents: Resident (R24) was observed on the common bathroom floor. R24 stated, she was trying to go to the bathroom. R24 did not have her wheelchair. Injury: face laceration, predisposing physiological factors: confused and gait imbalance predisposing physiological factors: decreased strength/endurance, predisposing situation factors: incident during unassisted self-transfer, not using wheelchair.

Nursing note dated 4/5/23 documents: approximately 1:05am resident (R24) was observed on the bathroom floor in between the stalls, on her left side in a sitting position. Blood was observed running down the left side of her face which resident was holding and crying. Upon assessment a small laceration noted with continuous bleeding. R24 returned with four stitches to left side of face near eye. Swelling noted. Nursing note dated 4/8/23 documents: noted four stitches to the left side of face near eye, with blue black ecchymosis and swelling. Care plan intervention dated 4/5/23 documents: Toileting program initiated for every 2 hours.

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Labs, refer to therapy. Wheelchair seat belt (it's not considered as restraint). Date initiated 4/6/23 documents: Restorative toileting program (every two-hour voiding pattern).

Restorative Nurse note dated 4/6/23 documents: R24 was given an attached wheelchair seat belt which could be released on voice command, it is not considered a restraint.

On 5/25/23 at 1:04pm, V3 stated, R24 had a fall on 4/5/23. R24 was at the nursing station and went to the bathroom by herself. The CNA went to do something, and the nurse turned her back for a minute. R24 was alert and orient to name (aox1). R24 sustained a laceration above the left eye. R24 was placed on a toileting program, given a seat which she could release, referred to therapy and medication modification. Restorative would toilet R24 during the day.

Fall event dated 4/11/23 documents: Staff alerted writer resident had a fall, upon assessment, resident noted in sitting position on floor in resident's room. Resident noted with open area with blood at the back of resident's head. R24 was alert to person. R24 has some difficulty communicating due to current psych issues. Predisposing Physiological factors: gait imbalance and decrease safety awareness.

Nursing note dated 4/11/23 documents: Staff alerted writer resident (R24) on floor, upon assessment, resident noted in sitting position on floor in room. Resident noted with open area and bleeding from back of skulls. Nursing note dated 4/12/23 documents: Resident went out due to a fall resulting in laceration of occipital region of scalp. Resident returned with orders to f/u (follow up) with her PCP (primary care physician) in ten

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days to have staples removed. Care plan intervention dated 4/11/2023: Bilateral floor mats. Care plan intervention dated 5/9/23 documents: R24 is non-compliant with helmet and attached seat belt on wheelchair.

On 5/25/23 at 1:04pm, V3 stated, R24 was found on the floor in her room. R24 got out the bed stood up and fell back. R24 had a helmet but would remove the helmet. R24 was redirected by restorative staff to keep the helmet on. The redirection worked sometimes but not all the time. We gave R24 bilateral floor mats.

Fall event dated 5/22/23 documents: R24 stated, she had a fall. Injury: bruise. Predisposing physiological factor: gait imbalance, decreased safety awareness, impulsive. Predisposing situation factors: not using wheelchair. Non-complaint with wheelchair. Resident is non-complaint with wheelchair and know how to get self-off of the floor if fall occurs.

Nursing note dated 5/22/23 documents: Resident (R24) stated she had a fall. Purple/reddish discoloration noted to right side chest, right side armpit, and right side. Care plan dated 5/22/2023 documents: R24 was sent to emergency room. R24 is non-compliant with helmet and attached seat belt on the wheelchair

On 5/25/23 at 1:04pm, V3 (don) stated, R24 reported she had a fall. We haven't determined the root cause of R24 bruises. Our investigation is on-going.

On 5/25/23 at 1:23pm, R24 was called at the hospital. R24 was not able to converse in comprehendible verbiage. R24 was not alert. Verbiage did not consist of any words.

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On 5/25/23 at 1:36pm, V36 (rehab director) stated, R24 was a fall risk, used a wheelchair and had poor safety awareness. I saw bruising on R24's chin and chest area. I reported it to nursing. R24 was able to transfer and walk with physical therapy. R24 could not walk by herself.

On 5/25/23 at 3:10pm, V61 CNA stated, R24 stumbles when she walks. R24 tries to get up and walk at least three times on my shift. If R24 hops up out of her wheelchair fast she would stumble. R24 was not on a toileting program. I've never seen restorative toilet R24. I would see R24 going to the bathroom, I would go behind her. R24 would walk behind her wheelchair pushing it. I didn't witness R24 fall.

Hospital paperwork dated 5/22/23 documents: Patient (R24) was sent for an unwitnessed fall. Found on the floor by nursing home staff. R24 had bruising in various stages of healing on the face and body. Extensive ecchymosis to the right side (chest wall, breast, axilla (underarm), shoulder, upper back and hip with upper thoracic tenderness, bilateral knees and left shoulder. Baseline alert and oriented times one (Aox1). Mumbles in response to question, unable to discern words. Diagnosis: fall, ecchymosis.

Fall policy dated 8/2017 did not apply.

(A)

Statement of Licensure Violations 4 of 4:
300.610a)
300.1010h)
300.1210b)
300.1210d)3)

Section 300.610 Resident Care Policies

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S9999	Continued From page 32 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 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	S9999		

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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.

These Regulations are not met as evidenced by:

Based on interview and record review, the facility failed to follow their nutrition at risk policy by not monitoring weekly weights and ordering labs for one resident. This affected 1 of 3 residents (R7) reviewed for adequate nutrition. This failure resulted in R7 experiencing an unplanned severe weight loss of 11.3% in 90 days.

Findings include:

On 5/18/23 at 11:09am, R7 alert and oriented stated she was not trying to lose weight and was not on any prescribed weight loss regimen. R7 stated she just started losing weight and had requested for lab work to be done but was never completed. R7 was unable to recall the last time her blood was drawn. R7 stated she was weighed a few weeks ago and the facility has not been weighing her weekly.
On 5/19/23 at 12:31pm, V38 stated he is unsure if he was notified of R7's weight loss. V38 stated if a resident experiences weight loss, they should notify himself or the nurse practitioner. V38 stated

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the resident would be evaluated by the dietician and follow their recommendations. V38 stated Labs would be ordered to monitor for any changes. V38 stated all of his patients have a standing order for labs to be drawn every 3 months and was unsure why labs had not been ordered. V38 stated the facility should have been weighing R7 weekly to monitor weights.

On 5/23/23 11:54AM, V44 (dietary tech) stated restorative is responsible for conducting the weekly weights and V44 will upload the weights in the computer under vitals. V44 was unaware of weekly weights for R7 and was unable to find any documentation of weekly weights for R7.
On 5/23/23 at 2:01PM, V3 stated weekly weights should be done be restorative. V3 was unable to find weekly weights for R7. V3 stated she did not see any recent lab results or orders for R7.
R7's weights dated: 2/7/23: 204 pounds; 3/6/23: 201 pounds; 4/12/23: 185 pounds; 5/8/23:181 pounds. 11.3% weight loss of 23 pounds compared to weight on 2/7/23. R7's medical record did not document any other weights or weekly weights.
R7's dietary progress notes dated 4/22/23 documents: Weight loss triggering for significant weight changes x (times) 30, 90 days. No reported edema. No recent hospitalization/ infection. Weekly weights/nutrition at risk review. Advise weight maintenance. Staff supervision at meals, monitor p.o. (by mouth) intake, weights, labs, skin, reassess as needed.

R7's medical record did not document any recent lab results. R7 labs results for Complete Blood Count, Thyroid level, lipid panel and Comprehensive Metabolic Panel were drawn on 8/17/22.
Facility policy titled Nutrition at Risk revised

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S9999	Continued From page 35 9/2018 documents: The facility will have a systematic interdisciplinary effort to identify, track, intervene and monitor residents that are high risk for weight loss, dehydration, and pressure ulcers. Residents are reviewed based on the following criteria: has experienced significant weight loss (5% in one month, 7.5% in 3 months or 10% in 6 months). (B)	S9999		