Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005854	A. BUILDING: ______ B. WING ______	C 04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL OF GLENVIEW,THE	1700 EAST LAKE AVENUE GLENVIEW, IL 60025

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S 000	Initial Comments Facility-Reported Incident of 1/30/23/IL157593	S 000		
S9999	Final Observations Statement of Licensue Violations 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. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 develop and/or follow any fall prevention policy and procedures; failed to implement fall-risk care plan interventions to ensure the resident's immediate environment was free of accident hazards; failed to adequately supervise and monitor residents; and failed to ensure assistive/alerting devices were in place to prevent accidental falls with injuries for 4 (R1, R2, R3, R4) of 4 residents reviewed for accident/hazards in the sample of 7 residents. Theses failures resulted in R1 sustaining multiple fractures to the face, ribs, and shoulder, R2 sustaining a hip fracture with surgical intervention, R3 with massive bleeding due to head trauma with required suturing, and R4 with head trauma, bleeding, and sutures. All 4	S9999		

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residents required emergent transfers to the hospital for medical treatment.

Findings include:

1. R1 is a 70-year-old having diagnoses listed in part with dementia, gait abnormality, lack of coordination, fracture of humerus, laceration of part of head, maxillary fracture, and fracture of body of mandible.

On 4/21/23 at 10:15 AM, V1 (Administrator) and V2 (DON/Director of Nursing) presented surveyor with R1's facility-reported incident of 1/30/23 and with all requested reportable and non-reportable incidents, along with incidents the facility was currently investigating. Interview with V2 stated, "R1 was observed falling from her wheelchair while in the dining room during dinner. The nurse heard R1's alarm go off but (V12) was unable to get to her in time. R1 fell to the ground, and she had a cut to her chin and was sent out to the hospital and came back with sutures but no other injuries."

Review of R1's progress notes contradicts V2's statement that R1 required only suturing when sent to the hospital. Facility progress notes written by V12 (LPN/Licensed Practical Nurse) dated 1/30/2023 22:15 showed, "Incident Note: Received a call from on-call guardian, stated that resident is admitted for observation due to lung bruising and rib fractures. DON (V2-Director of Nursing) notified."

V12 (LPN) wrote a subsequent entry in the progress note dated 2/2/2023 at 4:47 PM "Admission Summary: Readmitted this 70-year-old female with diagnosis of maxillary fracture, fracture of mandibular condyle,

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laceration of lips and chin, right side Pulmonary Embolism, Lower Left Extremity Deep Vein Thrombosis. Transferred resident to bed by ambulance crew. Resident is awake and verbally responsive. Confused and disoriented. Able to somehow respond appropriately to closed ended questions. Denies pain at this time. Notified MD/ NP, orders verified, noted, and carried out. On-call guardian notified of readmission, also consents obtained for psycho-therapeutic medications."

Hospital records dated 1/30/23 reads in part, "Date of admission: 1/30/2023. Chief complaint: Fall. History of Present Illness: (R1) is a 70-year-old female with primary history significant for general weakness, dementia, depression, epilepsy, right humerus fracture, presents due to witnessed fall at nursing home. Got up from bed and fell onto face. Reports mild pain around mouth. Very poor historian. Does not recall events. In the ER: found to have a pulmonary embolism, Multiple facial fractures. Assessment and plan: Suspected mechanical fall out of bed and sustained facial trauma-- fractures of maxilla and mandible, including into teeth. ER consulted plastics and maxillofacial surgeon. Started on antibiotics for head/neck coverage regarding lip laceration and facial fractures.

V1 (Administrator) and V2 (Director of Nursing) were interviewed again regarding the inaccuracies of V2's report showing R1's report of injury, V1 and V2 stated, "We're sorry, we just realized that the report was wrong and we will correct the report today to be submitted to your office." Surveyor asked if there were other omissions or inaccuracies not presented to surveyor, V1 and V2 stated, "No we reported everything to you."

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(Further review of V1 and V2's reports of accidents and incidents showed another facility-reported incident involving (R2) was not presented to surveyor as originally requested.)

R1's care plan dated 11/18/22 revised 3/22/23 reads in part, "R1 has had an actual fall due to dementia, poor balance, unsteady gait with witnessed fall on 11/17/22, unwitnessed fall on 11/26/22, witnessed fall on 12/2/22, unwitnessed fall on 12/23/22, and witnessed fall on 1/30/23. Goal: The resident will resume usual activities without further incident through the review date. Interventions: Resident will use a bed alarm to alert staff that the resident requires assistance; Resident will use geriatric chair to sit while in the dining room.

MDS (Minimum Data Set) assessment dated 3/21/23 showed R1 as having severe cognitive impairment and required extensive assistance in all activities of daily living including transfers and mobility. Further review of MDS assessment section P (restraints and alarms) showed no usage of bed or chair alarms as per R1's care plan. Review of R1's prior MDS assessments dated 12/23/22, 1/30/23, and 2/9/23 all show R1 as requiring extensive assistance in all ADLs (activities of daily living) and again do not indicate usage of any bed alarms or chair alarms to prevent R1 from continued falling.

Interview with V3 (Restorative Fall Nurse) on 4/21/23 at 2:30 PM stated, "I am in charge of the falls. I am the restorative nurse and fall nurse. " Surveyor asked about R1's last fall that occurred in January. V3 stated, "The nurses let me know about (R1)'s fall. I found out it happened when the staff were passing dinner trays and the resident fell when she got up from where she was sitting,

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S9999	Continued From page 5 and she fell forward. She got stitches to her chin when she went to the emergency room and then she came back. " Surveyor asked if those were the only injuries R1 sustained, V3 stated, "Yes, that's what we talked about as a team in the morning meeting the next day." Surveyor asked what team she was referring to, V3 stated, "The Administrator (V1), DON (V2), me, and all the department heads. We try to come up with good interventions to prevent falls and we usually refer all falls to physical therapy for working with balance and strength." Surveyor asked what fall preventative measures the facility used for high-risk residents, V3 stated," If they are unable to press the call light, we use bed alarms and chair alarms to alert staff." Surveyor asked if the facility developed a fall policy that the facility followed, V3 stated, "We don't have a fall policy, we just discuss it." Surveyor asked how she conveyed to staff how to prevent falls without a policy, V3 stated, "I don't know, but I will ask the DON." Surveyor asked if she was involved in training staff on how to prevent falls, V3 stated, "Yes. I do the in-servicing on fall documentation, and we did it during a skill fair last month." Surveyor asked if there were any programs or symbols for staff to follow to identify residents that were at risk for falls, V3 stated, "No we just discuss it, but what we last talked about with nurses was just how to document on falls." Surveyor clarified whether it was just documenting of falls when they occurred and not fall prevention that was in-serviced, V3 stated, "Yes, I just talked about documentation." Interview with V12 (LPN) on 4/21/23 at 2:30 PM, V12 stated, "I recall the incident with R1, that was during dinner time. I saw R1 on the other side of the hallway by the window maybe about 15 -20 feet away from me. I just saw her when she was	S9999		

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S9999	Continued From page 6 on her way down, falling. The CNA's and I tried to get to her. I recall V9 (CNA) running to catch her before she fell too. We both tried to rush to her, but she fell, and we couldn't get to her. R1 had some minimal bleeding when she fell, and we stopped that bleeding and she was assessed. I was there and other staff members came running in to help stop the bleeding and do an assessment." Surveyor asked if there was some sort of code to prompt other nurses to come rushing into the unit, V12 stated, "No. they probably just heard all the commotion." Surveyor asked if R1 only had minimal bleeding, why other staff rushed in to stop the bleeding, V12 stated, "They just tried to help me because I was busy trying to do other things like call the ambulance." Surveyor asked if there was any specific staff member assigned to monitor the residents in the dining area, V12 stated, " V9 (CNA) was supposed to watch R1 and the rest of the residents that day but the CNA's get too busy and have other duties." Surveyor asked if she could recall how many residents she normally took care of in the dementia unit, V12 stated, "If it's a full house we usually have 33 residents and I think we were full then. " Surveyor asked how many nurses and aides there were in the unit, V12 stated, "There are usually 3 aides. sometimes we get agency CNA's, but there's normally 1 nurse." Surveyor asked what fall prevention measures were discussed or she did training on, V12 stated, "Not too long ago we had a meeting and that was one of the subjects was about falls. Surveyor asked how she was trained to manage falls in the unit, V12 stated, "There's been so many falls here. I've been here 26 years in the facility, and we have a lot of falls. That seems a lot, but you know, people get weak, and we discuss falls on a case-to-case basis. These residents, when they get older, they get more	S9999		

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S9999	Continued From page 7 confused, so they will generally fall a lot." Surveyor asked what the facility did to prevent falls since, by her own account, there are a lot of falls, V12 stated, "Like I said, residents have a right to fall, we can't prevent them from falling as much as we try. It's just a case-by-case basis." Interview with V9 (CNA/Certified Nursing Aide) on 4/21/23 at 3:50 PM contradicts V12's (LPN) account of R1's incident. V9 stated, "I just tried to help her after she fell. I helped the nurse because she called for help." Surveyor asked what he was doing at the time R1 fell from her chair, V9 stated, "In this time I passed the trays for dinner, so I was not involved in that when (R1) fell, I just heard a loud boom (V9 clapping his hands in a hard motion), but I never saw her fall . When I heard a boom and I saw her on the floor and she was bleeding on her face and the nurse (V12) was shouting help! help! but I was busy passing trays, so I did not see her fall, I just heard a loud boom on the floor." Surveyor asked if the sound he heard was an alarm, V9 stated, "No she does not have an alarm, I heard her just fall because I heard just" boom" sound." Surveyor asked if he knows about the blue stars on the doors and when he was last trained on fall prevention, V9 stated, "I don't know what that is (referring to blue stars) but we get in-service all the time, I do not remember when." Efforts to reach R1's attending physician for interview were left unanswered. Interview with V14 (Medical Director) on 4/21/23 at 2:55 PM, "R1 is not my patient but I am involved with the quality assurance meetings which was just this past Wednesday of last week. . We talked about falls and standard discussions. I usually ask whether a fall was preventable or	S9999		

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S9999	Continued From page 8 could we have done something better. Sometimes falls are unpreventable falls due to psychiatric disorders, etc. Some repetitive fallers, we see if we can do something differently such as frequent rounding by staff, keeping the resident close to the nursing station, are they able to wear a helmet or use of a bed alarm or chair alarm, safety feature to the chair like anti-fallback mechanisms for the chair. We sometimes we ask families to come by more often because we can't have staff take the full burden of preventing falls." Surveyor asked whether R1 was discussed in one of their meetings, V14 stated, "Yes, I recall it was a pretty significant fall with fractures and the Administrator and Director of Nursing were all involved in discussing that fall." Surveyor asked who informed her of R1's fall with fracture, V14 stated, "V2 (Director of Nursing) was the one who told me because I remember we went through the standard questions and interventions and things, and I asked whether it was preventable." Surveyor asked if there was any consensus on whether the fall was preventable, V14 stated, "I'm not sure about that. I just know that there were evaluations done and I believe the staff initiated some additional interventions, but specifically for R1 I am not certain." Surveyor asked whether she knew if R1 fell prior to the last significant fall, V14 stated, "From what V2 told me, that was the only one." Surveyor asked if she was aware or had any further input with the falls occurring in the facility, V14 stated, "We discuss falls and I believe there has been some improvement. We've implemented a lot of different interventions specific to the resident and staff should ensure that these interventions are in place to make sure they are effective." Observations conducted on 4/22/23 at 11:53 am in R1's previous nursing unit showed 30 residents	S9999		

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in the dining area with 1 nurse (V15-LPN/Licensed Practical Nurse) present in the room and 3 aides currently assisting residents during mealtime.

Surveyor asked if she knew about R1, V15 (LPN) stated, "Yes, I remember her, but I was not here when she fell." Surveyor asked if R1 was one of the residents that had a chair alarm, V15 stated, "Yes, but they just started using it after that last fall in January." Surveyor asked if R1 was a frequent faller, V15 stated, "Oh yes, she has fallen multiple times, but she is very difficult to manage, she is always trying to sit up and get out of her chair." Surveyor asked whether someone with that history of behaviors and falling should have been on some assistive device to prevent falls, V15 stated, "Yes. We should have put a chair alarm and bed alarm on her sooner." Surveyor asked about the blue stars on resident doors and what they signified, V15 stated, "You know the DON (V2) was here and told me that I should know about these stars which mean the resident is a fall risk. I've been here over 20 years and no one's every told me about any blue stars, but he (V2) just told me I should know about the blue stars but never came back and did any in-service on them. " Surveyor asked if V3 (Fall Nurse) ever came to do training on the blue stars, V15 stated, "Never."

On 4/22/23 at 1:55 PM V1 (Administrator) was asked about the facility fall policy referred to as their "Falling Star Program", V1 stated, "we don't have a policy we just have meetings about who is at high risk for falls." Surveyor asked what the blue star decal on each door signified, V1 stated, "I don't really know but I will find out about it." Surveyor asked whether it was the responsibility of the Administrator to know about a falls program

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given that falls are discussed during their morning team meetings, V1 stated, "Yes, I should know but I will find out about the program and get back to you. V1 returned a half hour later and explained to surveyor that there was no policy or procedures pertaining to the "Falling Star Program" referred to by V15 but was in the process of being developed.

2. R2 is a 61-year-old having diagnoses listed in part with aphasia following stroke, anxiety disorder, gait abnormality, and fracture of left femur.

On 4/21/23 at 10:15 AM, V1 (Administrator) and V2 (Director of Nursing) were requested to present the incident reports pertaining To R1 and any other reportable incidents currently being investigated. V2 returned 30 minutes later and presented surveyor with R1's incident report but omitted presenting any report for R2. Surveyor asked again whether all reportable incidents including any ongoing facility investigations were presented to the surveyor, V2 stated, "Yes, I gave you everything."

A review of facility records discovered R2's fall incident not reported to surveyor as requested. Interview with V1 (Administrator) stated, "I discussed this with V2 (Director of Nursing) and it was just an error on his part." Surveyor reminded V1 that V2 also did not accurately report R1's fracture along with not providing R2's incident involving a fracture and asked how V2 could make several omissions for two very significant events. V1 responded that he would discuss this V2.

Facility progress notes show on 4/12/2023 04:45 V16 (RN) wrote, " Note Text: Prior to the incident,

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at around 4:00 AM, the resident was observed sleeping on her bed. At approximately, 4:45 AM, this writer heard the resident calling for help, this writer immediately rushed to the room, and observed the resident sitting on the floor next to her bed. When resident was asked what caused the fall, resident stated that she was trying to go use the washroom, but she lost her balance and fell. Head to toe assessment completed, resident complained of pain on the left hip area, left hip was kept immobilized, and resident sent out to ER for further evaluation."

On 4/12/2023 08:39 AM V17 (LPN) wrote, "Nurses Note: Resident complaints of pain on left leg and unable to move and stated that she might have broken something. Resident was moaning and crying due to pain. NP informed and sent out to ER to be assessed. Pain medication administered. Family informed and verbalized understanding. Resident picked up by ambulance at 9: 15 am, resident transferred from bed to stretcher with no issues. Documents and bed hold policy given to EMT."

On 4/12/2023 14:54, V17 (LPN) wrote: "Nurses Note: Called hospital for updates, RN stated that resident has been admitted to hospital for left hip fracture."

Care plan dated 1/2/2023 reads in part, "R2 is at risk for falls related to deconditioning, gait/balance problems, CVA (stroke). Goal R2 will be free of falls through the review date. Interventions: Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.

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Care plan dated 4/11/23 reads in part, "The resident has had an actual fall: unwitnessed fall on 4/8/23, unwitnessed fall on 4/12/23. Interventions: Physical therapy to evaluate and treat when resident returns from the hospital. Bed alarm will be provided to alert staff that resident requires assistance."

On 4/21/23 at 10:20 AM, R2 was observed in her room asleep laying in her bed. R2's call light was hanging from the right side of the bed on to the floor. At 12:19 PM, R2 was observed shouting out to the hall for help but did not have her call light activated. Surveyor entered R2's room and asked if she needed help, R2 tried to let surveyor know what she wanted but was unable to make clear sentences to convey what she wanted, so R2 pointed to the chair in the corner. R2's call light remained on the floor and her bed appeared to be waist high off the floor and not lowered to the ground. There were no floor mats or bed alarm that appeared to be on her bed. V9 (CNA) entered the room and had difficulty understanding what R2 wanted. R2 was able to say, "Water, I want water, white water." V9 left the room and came back with a pitcher of water. Surveyor asked V9 if the call light should be on the ground, V9 went over and placed R2's call light back onto R2's bed within her reach. V9 stated, "It was on her last time. Sometimes it falls down." Surveyor asked if her bed should be that high up from the ground, V9 stated, "No I will lower it down."

Interview with V3 (Restorative Fall Nurse) on 4/21/23 at 2:30 PM stated, (R2) fell trying to get up from her bed. The nurse assessed her, but it was an unwitnessed fall, and she sustained a hip fracture. We discussed her fall in our team meeting and we are going to have PT/OT pick her up. We placed a bed alarm, and she is able to

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follow command but we still caught her trying to get up herself. Even when we give her medication, she tries to get up. " Surveyor asked what other interventions the facility has tried to prevent R2 from falling, V3 stated, "That's all we do for her to prevent her from falling." Surveyor asked again whether there were any other preventative measures used for R2 but V3 (Restorative Fall Nurse) could not provide any other examples of assistive devices such as fall mats, call lights within reach, frequent monitoring, or low bed to prevent R2 from falling again.

Review of R2's progress notes on 4/23/23 showed a 3rd preventable fall:

On 4/23/23 at 04:08 am, V16 (RN) wrote, "Nurses Note: "She tried a couple of times to get out of bed but much better than yesterday .She followed Nurse instruction ." (There was no documentation as to what R2 needed from the nurse or what instructions or interventions V16 (RN) did to prevent R2 from falling out of bed.)

On 4/23/23 at 8:00 AM, V7 (LPN) wrote, "Incident Note. Prior to incident 7:30 a.m. resident was observed sleeping on her bed and bed set at lowest position with call light within reach and with bed alarm. Around 8:00 a.m. bed alarm went off and staff member rushed into the room and saw resident on the floor in an upright sitting position next to her bed. Staff alert this writer that the resident was observed on the floor. Writer quickly went to the room to check on resident and asked resident what happened, and resident stated she tried to get out of bed to go use the bathroom but felt weak and lost balance and fell. Head to toe assessment completed. No new redness or swelling noted, no shortening on any extremities. Resident verbalized pain in the back of her head.

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No bruise or lumps felt on back of head upon assessment at that time. Resident appeared agitated and anxious. No loss of consciousness. Able to move all extremities at baseline without complain of pain. Tramadol and Xanax given. Vital signs taken; Family notified and verbalized understanding. NP notified with orders to send the resident via 911 to hospital for further evaluation."

3. R3 is a 93-year-old diagnosed in part with Alzheimer's Disease, Chronic obstructive Pulmonary Disease, injury of the face, and traumatic hemorrhage of cerebrum.

R3's care plan with multiple dates reads in part, "R3 is at risk for falls related to gait/balance problems. On 2/19/21-resident fell in her room with laceration on top right forehead noted. sent to hospital for evaluation. On 10/23/21: Unwitnessed fall resulting in hematoma to chin. Sent to ER and returned without new orders. On 10/23 21: Witnessed fall. On 3/29/21 Witnessed fall; On 5/25/22 Witnessed fall, On 10/8/22-Unwitnessed fall; and on 4/8/23 Unwitnessed fall. Interventions: Resident will be close to the nurse's station for close monitoring; wheelchair axle lowered to ensure resident is sitting at the lowest position of the wheelchair; the resident uses chair and bed electronic alarm. Ensure the device is in place as needed."

A facility incident written by V18 (RN) dated 4/8/23 shows in part, "Prior to incident at around 2:50 PM, the resident was sitting on her wheelchair at the dining room. At approximately 3:00 PM, other nurse on duty observed the resident trying to get up from her wheelchair and ran to her but could not get to the resident on time to prevent the fall. Nurse on duty

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immediately went to assess the resident. Resident was laying on her right side and noted bleeding by her head. Head to toe assessment done. Applied pressure dressing and cold pack to stop the bleeding. Called 911 to send to the ER for further evaluation."

Facility incident report does not indicate whether a chair alarm activated nor identified the "other nurse on duty".

Interview with V2 (Director of Nursing) on 4/21/23 at 10:15 AM stated, "V18 (RN) wrote the incident report but she was not the one that observed this fall." Surveyor asked if V18 didn't observe the fall, why she made the entry in the nursing notes, V2 stated, "That's just how we do incidents here." Surveyor asked if R3 should have a chair alarm to alert staff if she stood up from the chair, V2 stated, "She should but I see that V18 didn't put that in her report, so I don't know whether she did or not."

On 4/11/23, R3 was readmitted back to the facility. V19 (RN) wrote in part: "4/11/2023 15:00 Admission Summary: Re-admitted this 93 year old, female white, from hospital per stretcher accompanied by 2 paramedics with the diagnosis of Frontal Lobe Hematoma, alert with periods of confusion and forgetfulness, physical assessment done, abdomen soft and non-tender with colostomy bag on right mid abdomen intact and patent, lungs field clear and no congestion, old bruise on right forehead with skin tear with 4 stitches, dry and clean , bruise on right eye."

Interview with V3 (Restorative Falls Nurse) on 4/21/23 at 2:30 PM stated, "(R3) is wheelchair bound and she was in her wheelchair at the time of this incident and she tried to get up and she fell

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because she doesn't have good balance. We had a chair alarm for her to prevent her from falling. V5 (RN) happened to be in same hallway when she attempted to prevent the resident from falling but the resident fell to the right side of forehead." Surveyor asked what fall preventative measures the facility used for R3, V3 stated, "We tried to encourage her to sit by the nurse's station because she moves herself and we try to get more supervision." Surveyor asked whether she was present during R3's fall incident, V3 stated, "No she fell over the weekend, so I did not see it, it was just reported to me and we talked about it in our morning meeting." Surveyor asked if she knew whether the chair alarm was activated for R3 as there is no indication of it in the incident report going off to warn staff the resident was about to fall, V3 stated, "I don't know for sure, I just know staff should have it on when R3 is in her wheelchair." Surveyor asked whether R3's latest fall was witnessed or unwitnessed as the care plan listed the fall as an unwitnessed fall, but the incident report showed it was witnessed, V3 stated, "I don't know."

4. R4 is a 90-year-old cognitively impaired resident with diagnoses of dementia, unsteadiness of feet, nondisplaced fracture of 5th cervical vertebra, fracture of shaft of humerus (left arm), and fracture of left rib.

R4's care plan showed previous falls: 15 unwitnessed and 2 witnessed falls. Care plan reads in part, (R4) is at risk for falls related to overactive bladder, osteoporosis, dementia, anxiety, major depression, and partial hearing loss. Interventions: The resident will be provided with a helmet to prevent injuries; Resident will use a bed alarm to alert staff that resident requires staff assistance; Offer and assist the resident to

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S9999	Continued From page 17 use the bathroom at night at least every 2 hours. Resident was provided visual reminders to call for assistance with activities of daily living; the resident uses chair electronic alarm. ensure the device is in place as needed." On 4/21/23 at 10:09 AM, R4 was observed in her room sitting on the edge of her bed. A bed alarm on the bed was not turned on nor activated while R4 was sitting at the edge of her bed. R4 was also not wearing a helmet as prescribed in her fall preventative care plan intervention. Interview with V3 (Restorative Fall Nurse) on 4/21/23 at 2:30 PM stated, " When R4 last fell (3/31/23), She tried to get up from the wheelchair. She got another cut to her right side of her head, and she was sent out 911. She received sutures." Surveyor asked how many falls R4 had and what the facility was doing to prevent further falls, V3 stated, "I know she fell a lot but we are using a geriatric chair instead of a wheelchair, we tried to use a geriatric chair and there is an alarm on her geriatric chair. I think we just put her on a geriatric chair after this last fall." Surveyor asked if R4 should be wearing a helmet and if there is also a bed alarm used, V3 stated, "I know we tried to use a helmet, but I don't know if she wears it. The bed alarm we use, and it should be on when she is in bed." A facility policy dated March 2018 titled "Assessing Falls and Their Causes" does not address fall prevention but shows policy and procedures for assessing falls after they've already occurred. This facility policy reads in part, "The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall.	S9999		

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S9999	Continued From page 18 There was no policy or procedures for the facility's "Falling Star" program for residents considered at-risk for falls. According to V1 (Administrator), the program policy had not yet been developed. (A)	S9999		