STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING _____ B. WING _____	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 62040

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 3 300.610a) 300.1210b) 300.3240a) 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 care and personal care shall be provided to each	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on interview and record review the facility failed to prevent misappropriation of resident property for 1 of 1 resident (R26) reviewed for misappropriation of property in a sample of 51. This failure resulted in R26 being upset and being a victim of theft of over $2000.00. Findings Include: On 5/3/2023 at 11:00 AM R26 was sitting up in her room in her chair. R26 stated she lived at the facility in the past and was discharged home then was recently readmitted to the facility. R26 stated she noted there were fraudulent charges on her bank card, but she didn't know what was going on because she had the bank card in her possession. R26 stated her family notified the local police regarding the fraudulent charges on her bank card. R26 stated the police told her and her family that a housekeeper that was employed at the facility took a picture of her bank card at the facility without her knowledge and made all purchases online. R26 stated she didn't know how someone had her bank card and she was told a housekeeper took a picture of her bank card and she spent over $2,000.00 at Amazon and Macy's among other stores. R26 didn't know what the housekeepers name was or if she ever met her. R26 stated she was very upset about the	S9999		

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fraudulent charges. R26 stated "This lady stole from me, and I don't have money like that."

The Facility's Undated Investigation, V1, Administrator documents, "(R26) is a 71-year-old female who admitted to the facility on 10/7/2022 and discharged on 12/21/2022. (R26) admitted with the following diagnoses: displaced intertotrochanic fracture of the left femur, spinal stenosis, heart disease, presence of a cardiac pacemaker, hypertension, hyperlipidemia, and major depression order. The resident is self-responsible and did sign her own paperwork upon admission to our facility. On 2/15/2023 at approximately 8:52 AM, I received a phone call from (V10), detective with local police department. (R26) had reported to her bank that there were charges on her bank card that she did not recognize. As the bank checked the charges, it was found that items purchased were shipped to the address of (V11, Housekeeping). (V10) asked this writer (V1) if I had a staff member by that name and I said that I did. (V11) was a housekeeping aide at the facility. (V10) asked me if she was here and I checked to see that she was clocked in. (V10) let me know the local police department would be coming to the facility to arrest (V11.) As I was on the phone with (V10), I had (V11)'s supervisor remove (V11) from the floor and placed her in the HK (housekeeping) supervisor's office. After hanging up, I waited on the police and directed them to the back of the building and (V11) was arrested on the charge of theft by the officers. They requested her purse and phone and the DON (Director of Nursing) retrieved both items. She was taken into custody without incident. The following was completed immediately: facility immediately removed (V11) from patient care area and sequestered her in office. Facility facilitated arrest of (V11.) IDPH

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S9999	Continued From page 3 (Illinois Department of Public Health) notified. Called (R26) and her family to give update, resident was readmitted to the facility on 2/15/2022. Communication between myself and (V10), detective. Administrator interviewed all housekeeping staff for information regarding this incident, with no findings. (V11) was subsequently booked into jail and charged with theft. The case number is 23-3411. I am awaiting information from the local police department about subpoenas of (V11's) of her phone to ensure that none of our other residents were affected by this employee. The staff member (V11) was hired on 6/1/2022. Upon hire, background check was initiated and there were no findings. Another background check was initiated subsequent to this offense, with no findings. The employee (V11) is obviously no longer an employee of this facility." On 5/2/2023 at 4:15 PM V1, Administrator stated R26 was readmitted to the facility. V1 stated the police contacted V1 to ask if V11 worked at the facility and V1 stated V11 was a housekeeper. V1 stated it was determined that the local police investigated R26's card transactions and it was found that V11 had ordered Amazon items and had them sent to her home from R26's bank card. The police came to the facility and arrested V11 and she was terminated the same day. V1 stated staff were interviewed and no staff stated they had knowledge of what V11 was doing. V1 stated the police didn't tell her how much about what V11 spent on R26's bank card. The police had to get a subpoena for R11's cell phone to be unlocked because she wouldn't give them the code and it was told to V1 that there were 13 other card numbers saved in V11's phone when the police unlocked it, but the officer stated no other facility residents were involved that they	S9999		

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S9999	Continued From page 4 were aware of. Residents and families of residents were also interviewed after both allegations and no other residents were affected by V11 and no other residents were missing money to the knowledge of V1. V11's Employee File showed the facility did a criminal background check on her prior to hiring her and she documented she received/reviewed and signed the facility abuse policy that included misappropriation of resident funds. The Facility's Abuse Prevention - Illinois Only, revised 10/22 documents "The facility is committed to protecting the residents from abuse. Definitions: Misappropriation of Resident Property: the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. Investigation: the facility will initiate at the time of any finding of abuse or neglect and injuries of unknown origin an investigation to determine cause and effect and provide protection to any alleged victims to prevent harm during the continuance of the investigation. The administrator must immediately report any instance of misappropriation of resident property, as well as report any reasonable suspicion of crime to the Illinois Department of Public Health and in accordance with regulations of with section 1150B of the Social Security Act to the Department of Health as required. Protection: any allegation of misappropriation or exploitation against any employee must result in his/her immediate suspension to protect the residents. All case of misappropriation of property must be thoroughly investigated, documented, and reported to the physician, families and/or representative, and as required by state guidelines. In addition, the	S9999		

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S9999	Continued From page 5 facility will follow Section 1150B of the Social Security Act's time limits for reporting a suspicion of crime. Reporting: the facility will report any knowledge of actions by a court of law against any employee, which would indicate unfitness for service as a nurse aide or other staff member to the state nurse's aide registry or licensing authorities. Alleged violations involving misappropriation of resident property, are reported immediately but not later than 2 hours after the allegation is made. Report the results of all investigations to the administrator or designated representative and other officials in accordance with state law including State Survey Agency within 5 working days of the incident." (B) 2 of 3 300.610a) 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 and dated minutes of the meeting.	S9999		

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S9999	Continued From page 6 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements are not met as evidenced by: Based on interview and record review the Facility failed to provide supervision to prevent elopement for 1 of 1 resident (R65) from eloping in the sample of 51. This failure resulted in R65 being transferred to local hospital and treated for abrasions. Findings include: R65's Face Sheet documents R65 was admitted to the facility 7/3/2021 with diagnoses of Dementia, Schizophrenia, Hyperlipidemia, and	S9999		

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S9999	Continued From page 7 Major Depressive Disorder. R65's Risk of Elopement Evaluation, dated 12/19/2022, documented R65 is alert and oriented has a history of leaving, increased risk, ambulates independently. R65's Care Plan dated 7/3/2021 documents "(R65) has a history of wandering and attempts to leave related to behavioral issues." The Care Plan documents she requires monitoring for safety. Interventions include "Frequent monitoring for safety". R65's Nurse's Notes dated 1/13/2023 at 8:36 PM document "Resident was last seen in her room at about 4:05 PM, during the evening med pass. Once I made it halfway up the hall, I was approached by a CNA (Certified Nurse's Aide) who was taking a smoke break when she realized that the residents window shade had been kicked out and the resident was missing. Every staff member in the facility was notified and we began the search. DON (Director of Nursing), Admin (Administrator), family and doctor were notified, and patient was found in less than 5 min (minutes) a block over hiding behind a bush near the (local business). Res was aroused and aggressive with staff once she made it into the building and also refused body assessment and vitals. EMS (Emergency Medical Service) was called and when they arrived she allowed them to talk with her and take her vitals. Res is currently at (local hospital) in the behavior department." R65's local hospital emergency department, ED, records, dated 1/13/2023 document R65 presented from the facility to ED complaining that R65 asked staff to open window and they would not. The ED Record documented R65 proceeded	S9999		

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to kick out the window and was found walking down the street. The ED Record documented R65 being sent in for psych evaluation. The ED History and Physical documents R65 requested the window open but staff refused. The ED Record documented R65 kicked out window and was found wandering outside the nursing home. ED Record documented exam revealed R65 has an abrasion of 0.75cm on tip of the nose. No fractures to nose or facial bones. R65's discharge instructions document diagnosis of abrasion to nose.

R65's Nurse's Note, dated 1/17/23 at 10:06 AM, documented R65 had a Brief Interview of Mental Status (BIMS) score of 13 indicating she was cognitively intact.

R65's Nurse's Notes Addendum dated 1/18/2023 at 10:31AM documented a Note Clarification for 1/13/2023 5:50PM. The Note documented "CNA came to this nurse to inform me that the window in one of the rooms looked to be kicked out. When she came in to check the room, the window was opened, and the resident assigned to the room was not present. I immediately went to look and (R65) was not in her room. This resident does not come out of room. I alerted all staff per facility policy by calling a Dr. Wander for elopement. Staff began searching the facility. I then notified ED (Executive Director) /DNS (Director of Nursing Service), Nurse Manager, and Hospice. The Note continued "6:01 PM, (R65) was located and returned to the facility by staff. Staff reported that they retrieved her from the business complex about 1 block from the facility. She was in front of the (local business) going behind the shrubbery. It seemed like she was attempting to hide. As (R65) was brought into the facility she was irate and yelling out.

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When I attempted to ask her why she left, she stated 'I', hungry. I want some real food and I'm not eating that s***.' She then requested heat because she was cold. I attempted to perform a skin and pain evaluation on her, but she refused. She was wearing a long-sleeved fleece sweater, long pants, socks, and rubber soled shoes. She also had a blanket wrapped around her shoulder. The temperature was 28 degrees, she was not appropriately dressed for the weather."

On 5/4/2023 at 3:45PM V1, Administrator stated R65 rarely comes out of her room. V1 stated R65 wants to be by herself. V1 stated she is in that room because she wants to be by herself and can't get along with any other roommates. V1 stated "She is very picky about food, but never comes out of her room. Activities cannot get her out, nobody can. That's the only private room in the facility. The door next to it is an alarm door. (R65) knew what she was doing, she put on all these clothes. She didn't go out the door, she got dressed and put on the clothes and kicked out the window." V1 stated "POA (Power of Attorney) declined R65 going to another facility. V1 stated R65 is not cognitively impaired. R65 very full well knew what she was doing, and she is here because she is schizophrenic. V1 stated R65's safety awareness is poor because she has a mental health condition. V1 stated it was a screen R65 kicked out to get out of window and all windows slide open.

On 5/4/23 at 3:31 PM, V2, Director of Nursing, DON, stated on Jan 13, 2023, it was about 5-6PM, "I got a phone call that said they couldn't find (R65). When I interviewed the staff, I was told (V31, Certified Nursing Assistant, CNA), went outside the North (100 hall) door to smoke and noticed there was some damage on the window. I

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was notified by (V32, Unit Manager), at the time. (V32) said they couldn't find her. (V31) came in to look at the room with the window damage. (V31) realized (R65) was not in the room and informed (R65's) nurse. (V13, Licensed Practical Nurse/LPN) did a 100% head count. We counted all the residents which took about 5 minutes max. I live about 30 minutes away, before I even made it more than a few minutes, they had already retrieved (R65). The reason we know how long it took is because (R43) was on the front porch. (R43) said he saw someone walking. She walked right by. It wasn't totally dark, but it was getting dark. V2 stated when the staff asked R43 if he had seen anyone, he pointed in the direction he thought R65 was going. V2 stated "One of the nurses, (V33, LPN), and (V21, CNA), got in the car and drove in that direction. When they got over that way, they saw a small figure going behind a shrub at a business complex. (V21) got out and it was (R65)." V2 stated R65 yelled a bit; they got R65 in the car and brought her back. V2 stated R65 had on terrycloth slippers with rubber soles, sweatpants, fleece, and blanket. V2 stated when they got R65 back, she yelled and screamed. R65 said she didn't want the food in the dining room and was going to look for food. R65 didn't go back to her room; we immediately sent her out just to be evaluated. V2 stated R65 had a tiny 0.5-centimeter (cm) abrasion on her nose, and they took her out to the hospital. V2 stated R65 was in room on the dementia unit. V2 stated R65 stood on her bed and kicked the screen out. V2 stated R65 was on the memory unit and was moved off for behaviors but didn't get along with anybody and was still high functioning at that time. V2 stated "When I moved her off the hall (memory unit), I put her on the short hall, but she had a roommate, and they didn't get along. Another roommate on north hall,

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didn't get along. So, I had to get her a private room." V2 stated R65's safety awareness is poor because she has diagnosis of dementia and is also schizophrenic.

On 5/3/2023 at 2:00PM V12, LPN, stated "(R65) didn't want to be here. She would say we couldn't make her be here." V12 stated R65 spoke this prior to the 1/2023 elopement.

On 5/3/2023 at 4:00 PM V13, LPN, stated "I was working the day (R65) left the facility. I was passing meds and saw her in her room around 4pm. At closer to 5:00PM (V31, CNA) was out smoking and came in saying that (R65's) window was out. I ran to (R65's) room and saw she was gone. I alerted everyone in the building and called 911. I was running all over searching inside and outside. We found her in about 10 minutes. When (R65) came back, I saw she had an abrasion on her nose. She wouldn't let me touch her. She let EMS take her and I heard her say to EMS she wanted out of here. (R65) has a lot of behaviors. She cusses, kicks, and yells. She is in the same room she was in before."

On 5/5/2023 at 8:54 AM V24, Nurse Practitioner (NP) stated she was aware R65 eloped from the facility in January 2023. V24 stated R65 has multiple psychiatric diagnoses including schizophrenia and should not have been outside the facility by herself. V24 stated R65 does not have safety awareness, that is why she is in a nursing home, so they provide oversight. V24 stated R65 didn't have exit seeking behavior but exhibited agitated and aggressive behavior but not exit seeking. V24 expects the facility to provide protective oversight and keep all residents safe, she also expects staff to follow the facility's policies and procedures.

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S9999	Continued From page 12 Facility elopement policy updated 5/2022 documents "The Unit Charge Nurse is responsible for knowing the location of their residents. When residents are participating in various programs, such as physical therapy, recreational activities, dining, etc. The staff in these programs will be responsible for the locations of their participants. It is the responsibility of all personnel to report any resident attempting to leave the premises or suspected of being missing to the Charge Nurse as soon as practical." (B) 3 of 3 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 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 13 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 made by nursing staff and recorded in the	S9999		

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S9999	Continued From page 14 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 requirements are not met as evidenced by: Based on interview, and record review, the facility failed to implement safe transfer techniques and implement progressive interventions to prevent falls and accidents for 2 of 2 residents (R59, R62) reviewed for supervision to prevent accidents in the sample of 51. The facility failed to obtain timely emergency medical services for the treatment of a fracture for one of one resident (R62) reviewed for quality of care in a sample of 51. This failure resulted in delay of treatment after R62 fell sustaining an acute and nondisplaced distal radial fracture as well as an acute fracture of the ulna styloid. Findings include: R59's Face Sheet documents an admission date of 4/7/2021, with diagnoses of Hemiplegia following cardiac infarction affecting left nondominant side, Seizures, Unspecified Pain, and Major Depressive Disorder. R59's Incident Report, dated 1/2/2023 at 3:10PM documents R59 was in the process of being transferred by 3 staff members with the mechanical lift when one of the straps broke from the mechanical lift pad causing her to fall back into her chair and she then slid to the floor. R59	S9999		

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had no injuries during fall and did not hit her head on the way down.

Facility's weight log documents on 1/9/2023 R59's weight was 364.2 pounds.

R59's Minimum Data Set, MDS, dated 1/12/2023 documents R59 has no cognitive deficits and is totally dependent on staff for transfers.

R59's Care Plan with a signature date of 1/2/2023 documents R59 is at risk for falls related to needs mechanical lift assistance for transfers, is incontinent, seizures, slide when up in wheelchair at times, Cerebral Vascular Accident with hemiplegia affecting left non dominant side and receives psychoactive drugs. Diagnosis of hypertension and is being treated for this. Interventions include dycem in seat of wheelchair, use of reclining high back wheelchair when up, assist as needed to adjust body position when up, administer medications as ordered, keep call light in reach, assist of 2 to 3 staff with mechanical lift transfers. Skin/pain assessments, passive range of motion after issue, reevaluated weight capacity of mechanical lift, new slings ordered/received, increase staff presence during transfers.

R59's Nurse's Note, dated 1/2/2023 document R59 was being transferred by 3 CNAs when the mechanical lift pad strap broke while R59 was in the air hovering over her wheelchair. R59 then slid to the floor. The Note documented a full body assessment was completed and R59 did not complain of any pain or had any injuries. The Note documented R59 was then rolled back on to a mechanical pad where she was lowered to her bed and performed a safe transfer.

On 5/5/2023 at 9:00 AM V2, DON, stated, "The

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S9999	Continued From page 16 CNAs were getting (R59) up in mechanical lift and one of the straps on the lift pad broke. (R59) landed on the bed or chair. She had no complaints of pain. I ordered more lift pads that are weight appropriate. My understanding is that the lift pad loops were frayed, but the pad was the appropriate weight. Laundry staff is now assessing the pads and loops. The pad that tore with (R59) on it shouldn't have been in circulation." 5/3/2023 at 4:00PM V13, Licensed Practical Nurse, LPN, stated "I was working the day (R59) fell from the mechanical lift on 1/2/2023. I was working on the hall and 2 or 3 CNAs were putting (R59) in bed using the mechanical lift. (V12, LPN) came out of (R59's) room and said one of the lift's straps had snapped. (R59) must've been too heavy. (R59) was laying down and myself, (V12), and 3 CNAs transferred (R59) up in a new mechanical lift pad. (R59) had no complaints. The pad we were using was the biggest pad we have. The staff assisting to get her up were V12, V19, CNAs, and V16, CNA." 05/04/23 09:45 AM V16 stated "I was in the room with 2 other staff, and we were transferring (R59) from the chair to the bed. During midair one of the strap's loops just broke. There are 4 straps and one of the loops just snapped. (R59)'s head hit another CNA, and then went to the floor gradually. We got other people to assist to get (R59) up off the floor. The nurse assessed (R59) and she didn't have any complaints. We have 2 mechanical lifts. One is a 450# max weight, and the other lift is 600# max. The lift pad we use for (R59) is larger and darker blue. We always use 3 people for transfer (R59). After this incident with (R59) we had a facility wide in-service on transfers. There is now a sheet in housekeeping	S9999		

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that they have checked the straps. The pads are washed daily, so housekeeping checks the straps."

05/04/23 10:44 AM V19, CNA, stated "I have worked here 3 years. In January I was in (R59)'s room with (V12), (V16) and (V21). (R59) was in her chair and we were putting her in her bed. We had (R59) hooked up to the mechanical lift and when she went up, one of the straps snapped. I stuck my leg out and she landed on my leg. (R59)'s head landed on my leg. We let her lay for a second and got her vitals. We got another lift pad under her. We got her in bed. She wasn't hurt at all. (R59)'s lift pads have numbers on them. They get washed every day. I check the loops. The loops looked warn and frayed, but they looked like they could hold her. We use mechanical lift (Brand name of Full Body Mechanical Lift.)"

05/04/23 12:30 PM V25, Laundry, housekeeping, stated "We wash the mechanical lift pads every time they are sent to us. I have a chart and inspect the pads monthly. I did not begin inspecting the lift pads until February."

Facility policy dated 8/2016 documents "The (Brand Name Full Body Mechanical Lift) is to be used for total lifts to obtain a resident's weight from bed to chair, chair to bed, or from the floor (maximum lifting per manufacture's guideline). (Brand Name Full Body Mechanical Lift) capacity is less than 450#. (Brand Name Full Body Mechanical Lift) weight capacity is less than 600#."

R47's Physician Order Sheet (POS) dated 09/10/21 documents "weakness", "Unsteadiness on feet", "other abnormalities of gait and mobility",

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"Alzheimer's disease with early onset."

R47's MDS dated 5/4/23, documents R47 has severely impaired cognition. The MDS also documents that R47 requires extensive assistance of two plus persons for locomotion on unit and locomotion off unit. The MDS documents R47 is not steady, only able to stabilize with staff assistance.

R47's Care Plan dated 07/27/22 documents "(R47) is at risk for falls related to impaired thought processes. Diagnosis of epilepsy, unspecified dementia without disturbance, Alzheimer's disease, and CVA with left sided weakness, needs assistance with transfer, is impulsive, and is incontinent of bowels and bladder." The Care Plan documents R47 had falls on 11/21/21, 11/29/21, 10/11/22, 10/17/22, 12/09/22, and 01/09/23. R47's Care Plan Interventions dated: 11/21/21 documents bolster mattress to his bed. R47's Care Plan Intervention dated 11/29/21 documents Give frequent reminders to call for assistance with transfers. R47's Care Plan Intervention dated 10/11/22 documents remind to call assist with ADLs, transfers, mobility, toilet before each meal. R47's Care Plan Intervention dated 10/17/22 documents for therapy eval for transfer/gait imbalance. R47's Care Plan Intervention dated 12/09/22 documents to educate R47 on follow up importance of notifying for staff to assist him to bed. Refer to skilled therapy for balance and transfer. R47's Care Plan intervention dated 01/09/23 documents skilled therapy to evaluate for trunk strengthening/balance, abdominal assessment: urinary retention foley inserted.

R47's Fall Investigation dated 10/11/22 documents "Resident had come back from the

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dining room before supper and attempted to put himself on the toilet in the North Hall shower room. I was at the nurses' station when I suddenly heard yelling coming from the shower room. When I approached the shower room resident was laying on his side. Resident stated he did not hit his head during the fall, explained to be that he was not hurt when asked and showed no sign of pain during ROM and no signs of physical injuries. Reminded to seek assist with ADLs toileting, and transfers. Toilet before meals."

R47's Nursing Note dated 10/12/22 at 8:59 PM documents "Late entry 10/11/22 resident attempted to put himself on toilet in the shower room without help during supper time. Res (Resident) was found on the floor in the shower room on the floor laying on his side. When asked did he hurt anything or hit his head resident stated "no." There were no physical injuries during head-to-toe assessment. No pain during ROM (range of motion). Resident was warned to not transfer himself to the toilet without staff assistance. Will continue to monitor."

R47's Nursing Note dated 10/17/22 at 1:33 PM documents "resident was in the shower and was holding rail and CNA (Certified Nursing Assistant) was trying to have resident sit in shower chair and resident wouldn't let the handle go and was going to the ground and the CNA lowered him to the floor res has no injuries noted or c/o (complaint of) pain noted at the time POA (Power of Attorney) notified and don (Director of Nursing) and NP (Nurse Practitioner) here and made aware."

R47's fall investigation dated 10/17/22 documents "resident was in the shower and CNA was having resident stand up to get into the shower chair and

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S9999	Continued From page 20 was holding the rail to stand up and when the CNA got him to stand up, he wouldn't stay standing so the 2 CNAs lowered to the floor. Therapy to eval for transfers and gait imbalance." R47's Nursing Note dated 12/09/22 at 8:02 PM documents "Resident tried to transfer himself from his wheelchair to his bed and fell on the floor." The Note documented "Resident stated he hit his head. Neuro checks in place. Brother (V34) called no answer message left. PCP (Primary Care Physician) aware. DON notified." R47's fall investigation dated 12/09/23 documents "Resident tried to transfer himself from his wheelchair to his bed and fell on the floor. Resident stated he hit his head. No injuries noted. Resident educated on the importance of waiting for staff to assist him to bed, refer to skilled therapy for balance and transfers." R47's Nursing Note dated 01/09/23 at 2:03 PM documents "T (temperature) 98 P (pulse) 96 R (respirations) 20 B/P (blood pressure) 156/90 at approx. 11 AM writer was called into room 124 by CNA staff. Writer entered room and found resident on floor besides his bed. Resident had cut above his right eye. Resident had c/o pain to his stomach. Resident stated that he was attempting to pull himself up with side rails and fell OOB. Resident was placed on neuro-checks that were WNL (within normal limits). Writer notified on call nursing supervisor and facility NP. Writer notified resident POA (V34). Resident received new order per (V24) FNP (Family Nurse Practitioner) to be sent to ER (Emergency Room) for evaluation. (Local Ambulance Service) arrived to facility at approx. 1:25 PM. Resident taken to (local hospital)."	S9999		

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S9999	Continued From page 21 R47's fall investigation dated 01/09/23 documents "At approx. 11 AM, writer was called into room 124 by CNA staff. Entered room and observed resident on floor besides his bed. Resident had a cut above his right eye. Resident had c/o pain to his stomach. Resident stated that he was attempting to pull himself up with side rails and fell OOB (out of bed). Resident was placed on neuro-checks that were WNL. Writer notified on call nursing supervisor and also facility NP. Writer notified resident POA (V34). Resident received new order per (V24) to be sent. Small superficial laceration to right eyelid. Skilled therapy to evaluate for trunk strengthening and balance, abnormal assessment: urinary retention observed, (indwelling) catheter inserted." On 5/5/2023 at 1:10 PM, V2 Director of Nurses (DON) stated when a resident falls, she expects the nurse to immediately assess the resident and to ensure the resident is safe. If staff can pick the resident up off the floor safely, she expects them to. The charge nurse should assess the resident for injuries and pain and assess the root cause of why the resident fell. After each fall V2 expects staff do to document progressive interventions to prevent the resident from falling again. V2 stated she expects the nurse to document the fall details in the resident's nurse's note in the electronic medical record. R62's Undated Face Sheet, documents she was admitted on 2/3/2021. R62's Care Plan dated 2/16/2021 documents, "Resident is at risk for falls psychoactive drug use, diuretic therapy and impaired cognitive skills. Diagnosis of hypertension and is being treated for this. Goal: falls/injuries minimized through the management of risk factors while maintaining	S9999		

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maximum independence through the review date. Approaches: administer medications as ordered by MD (physician)/NP (nurse practitioner.) See POS (physician order sheet)/MAR (medication administration record.) Keep call light within reach when in room, ensure that she is wearing proper footwear when ambulating. She is able to transfer and ambulate independently. PT (physician therapy)/OT (occupational therapy) as ordered. Vital signs as ordered. Notify MD/NP of abnormal results. Perform a fall risk evaluation assessment on me quarterly and PRN (when needed.) 7/5/2022 fall without injury skin/pain evaluation PROM (passive range of motion) without issue, skilled therapy for evaluation for reacher. 8/12/2022 fall without injury approach added floor path clear from hazards footwear inspected proper footwear in place at all times. 9/25/2022 fall without injury approach added footwear inspected family representative to bring in proper fitting shoes. No progressive intervention was documented on R62's care plan after the 9/25/2022 fall.

R62's Fall Scale, dated 9/25/2022, documents total score 40 which was low to moderate risk action: implement standard fall prevention.

R62's Quarterly Minimum Data Set (MDS) dated 10/10/2022 documents R62 is severely cognitively impaired, supervision with walk in room and corridor, supervision with dressing, limited assistance with one-person physical assist for personal hygiene. R62's MDS documents steady always during balance during transitions and walking and uses mobility devices.

R62's Nurse's Note, dated 10/31/2022 no documentation of fall.

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S9999	Continued From page 23 R62's Bath Skin Assessment dated 10/31/2022, V12, Licensed Practical Nurse (LPN) documents, "No swelling, bruising or redness to right hand, fingers or wrist at time of fall." R62's Pain Management Evaluation Tool, dated 10/31/2022, form was blank, no pain assessment documented. R62's Nurse's Note, dated 11/1/2022 at 4:46 AM V38, LPN documents, "Resident continues on incident follow up for fall, resident right 3rd digit bruised and edematous, right wrist edematous and bruised, call placed to FNP (family nurse practitioner), and order received for Xray to right hand and wrist." R62's Nurse's Note, dated 11/1/2022 at 6:03 AM V38, LPN documents, "Resident's family representative notified and Xray company notified of order for Xray to right hand and wrist. Xray will be out today." R62's Patient Xray Report, dated 11/1/2023, documents "Right hand, 2 views findings: acute and nondisplaced distal radial fracture as well as an acute fracture of the ulna styloid. Joint spaces preserved. Soft tissues are unremarkable. Impression: distal radial and ulnar styloid fractures. Right wrist 2 views findings: nondisplaced acute fracture of the distal radius as well as an acute ulnar styloid fracture. Joint spaces preserved. Soft tissues are unremarkable. This form was electronically signed by a physician on 11/1/2023 at 9:07 AM." R62's Nurse's Note, dated 11/1/2022 at 11:42 AM V28, LPN documents, "Resident had a fall evening shift 10/31/2022, the night nurse called Xray company as residents rt (right) wrist and	S9999		

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S9999	Continued From page 24 hand was swollen and resident had a complaint of pain. Xray company called this nurse with results, stated that resident has a distal fracture of the radial and ulnar styloid physician notified, who evaluated resident as well stated to send to ER (emergency room) for evaluation and treatment. Physician ordered Tylenol 650 mg for pain. DON (Director of Nurses) and ED (Executive Director) notified." R62's Nurse's Note, dated 11/1/2022 at 8:10 PM V12, LPN documents, "10/31/2022 2P-10P shift around 4 PM resident was sitting in common area by the dining room mingling with other residents. Resident attempted to assist another resident from one chair to another causing them both to fall to the floor. Resident was assisted off the floor. Pain/skin assessment, ROM (range of motion) and VS (vital signs) were done. Resident was able to move fingers and wrist but complained of some pain. Tylenol was given. Resident sat at dinner table for supper. After dinner resident went to room to prepare bed with no further complaints and rested quietly throughout rest of shift. Resident ambulates independently and had shoes on. The floor was dry. Resident toilets self." R62's Medication Administration Record (MAR) dated 10/31/2022 documents no pain medication including Tylenol was administered on 10/31/2022 or 11/1/2022. R62's Nurse's Note, dated 11/1/2022 at 8:57 PM V37, LPN documents, "Resident sent to local ER via ambulance at 5:00 PM. Resident returned from ER at 8:00 PM with short arm OCL (splint.) Resident has fx (fracture) to radius and ulna styloid. It is recommended that resident follow up with physician in 2-3 weeks. FNP and family	S9999		

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	IL6010441	A. BUILDING: _____ B. WING _____	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 25 representative notified of dx (diagnosis) and return. Resident did have a moderate amount of swelling to hand and wrist before leaving unit. Swelling still present. Radial pulse present. Negative for heat to area. Resident currently in room resting with eyes closed." R62's Local Hospital Discharge Instructions, dated 11/1/2022 documents, "Diagnosis pain in right wrist fracture of radius and ulna styloid." On 5/4/2023 at 11:00 AM, V12 LPN stated she worked 8:00 AM to 4:00 PM day shift as the facility's Infection Control Preventionist (ICP.) V12 stated she worked as a nurse on the floor from time to time and on 10/31/2022 and was assigned to R62 evening shift. V12 recalled R62 fell on the evening shift, and she assessed R62 for injuries at that time and there were none. She reported to the night shift nurse that R62 fell. On 5/4/2023 at 2:15 PM V28, LPN stated she worked 5:45 AM to 2:00 PM day shift on 11/1/2022 she received nurse report (unknown name) from the night shift nurse who reported R62 fell. V28 stated when she assessed R62's right arm that afternoon it was swollen and bruised and R62 complained of pain. V28 stated R62's physician, V29, was at the facility that morning and had assessed R62's right wrist and stated to send her to the ER. V28 stated she didn't recall if she called 911 or if she called for a non-emergency ambulance when V29 stated to send R62 to the ER. V28 stated "If you don't call 911 it can take hours for the non-emergency ambulance to get to the facility." V28 could not recall if R62 was transferred to the ER prior to leaving the facility that day, if R62 was still at the facility she would have given the next shift nurse report regarding R62's fall and the need to go to	S9999		

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S9999	Continued From page 26	S9999		

the ER.

R62's Care Plan was not updated after this fall with progressive interventions.

On 5/5/2023 at 1:10 PM, V2 Director of Nurses, DON, stated when a physician tells staff to send a resident to the emergency room, she expects staff to call 911/lights and sirens for a resident that a fall and Xray showed 2 fractures and is symptomatic meaning the resident has swelling, bruising and pain. V2 stated she was not aware of a resident that fell, had a complaint of pain with bruising and swelling and waited at the facility for an ambulance to take her to the emergency room for over 5 hours. V2 stated when a resident falls, she expects the nurse to immediately assess the resident and to ensure the resident is safe. If staff can pick the resident up off the floor safely, she expects them to. The charge nurse should assess the resident for injuries and pain and assess the root cause of why the resident fell. After each fall V2 expects staff do to document progressive interventions to prevent the resident from falling again. V1 expects the nurse to document the fall details in the resident's nurse's note in the electronic medical record.

On 5/5/2023 at 8:54 AM V24, Nurse Practitioner stated she was the nurse practitioner for V29, Physician. V24 stated when a resident falls, she expects staff to document what occurred with the fall and if the resident sustained injuries from the fall in the resident's medical record the same day the fall occurred. V24 stated when V29 gave the physician's order to send R62 to the hospital after R62 fell, she would have expected staff to get R62 to the hospital pretty quickly within an hour, especially when the Xray report documents R62 had fractures from the fall. V24 stated she

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S9999	Continued From page 27 expected facility staff to follow physician's orders and facility policies and procedures. The Facility's Notification of a Change in A Resident's Status revised 11/17, documents, "Policy: the attending physician/physician extender (Nurse Practitioner, Physician Assistant or Clinical Nurse Specialist) and the resident representative will be notified of a change in a resident's condition, per standards of practice and Federal and/or State regulation. Responsibility: All Licensed Nursing Personnel. Procedure: Guideline for notification of physician/responsible party (not all inclusive) any accident or incident (per Federal and State regulations.) Document in the Interdisciplinary Team (IDT) notes: resident change in condition, physician/physician extender notification and notification of responsible party." The Facility's Accident & Incident Documentation & Investigation Resident Incident revised 7/2018, documents "Policy: accidents and/or incidents involving resident care will be investigated and documented on the Resident Incident Report entry form in the LTC (long term care) system. An "incident" is defined as an occurrence which is not consistent with the routine operation of the facility or the routine care of a particular resident. Accident and incidents will be analyzed for trends or patterns to enable the facility to enhance preventive measures to reduce the occurrence of incidents." The Policy documents "The Licensed Nurse assigned at the time of the time of the resident care accident/incident is responsible for conducting an investigation of the circumstances surrounding the accident/incident, and for notifying the Supervisor, Director of Nursing, and/or the Executive Director as appropriate. The Licensed Nurse at the time of the incident is responsible for initiating/completing the Resident	S9999		

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S9999	Continued From page 28 Incident Report, ensuring that all items identified on the form have been completed as applicable to the accident/incident. The Licensed Nurse at the time of the incident is responsible for documenting the incident in the resident's medical record, in accordance with the guidelines below and set forth on the Resident Incident Report." The Policy documents "The Nurse's Notes could contain the following documentation: date and time of incident: clear, objective facts of what occurred; the last time the resident was seen prior to the incident; An evaluation of the resident's condition at the time of the accident/incident could include a description of the resident, vital signs, and any other physical characteristics apparent as a result of the accident/incident; an treatment provided; any contacts made or attempted with the resident's physician, family, legal representative or any other health care professional or person involved with resident's care; The resident's outcome and any information concerning the incident and the Nurse's signature, date and time of the charting." (B)	S9999		