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
	IL6005292	A. BUILDING: ____ B. WING ____	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENA LIVING CENTER	1010 SOUTH LOGAN STREET LENA, IL 61048

(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 Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.615e) 300.615f) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. This REQUIREMENT was not met as evidenced by:	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1 Based on record review and interview, the facility failed to submit background checks, check the Illinois Department of Corrections (IDOC) website, and check the Illinois State Police (ISP) website within 24 hours of admission. This applies to 7 of 10 residents (R218, R368, R369, R370, R371, R372, R373) that were reviewed for criminal backgrounds in the sample of 10. The findings include: R218's electronic face sheet showed R218 was admitted to the facility on 5/11/23. R218's IDOC and ISP checks were completed on 5/24/23 (13 days after R33's admission). R368's electronic face sheet showed R368 was admitted to the facility on 5/19/23. R368's background check, IDOC, and ISP checks were dated 5/24/23. (5 days after R368's admission) R369's electronic face sheet showed R369 was admitted to the facility on 5/11/23. R369's IDOC and ISP checks were completed on 5/24/23. (13 days after R369's admission). R370's electronic face sheet showed R370 was admitted to the facility on 5/19/23. R370's background check, IDOC, and ISP checks were dated 5/24/23. (5 days after R370's admission) R371's electronic face sheet showed R371 was admitted to the facility on 5/9/23. R371's background check was dated 5/12/23. (3 days after R371's admission) R371's IDOC and ISP checks were completed on 5/24/23. (15 days after R371's admission).	S9999		

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Continued From page 2

R372's electronic face sheet showed R372 was admitted to the facility on 5/12/23. R372's IDOC and ISP checks were completed on 5/24/23. (12 days after R372's admission).

R373's electronic face sheet showed R373 was admitted to the facility on 5/10/23. R373's background check was dated 5/12/23. (2 days after R373's admission) R373's IDOC and ISP checks were completed on 5/24/23. (14 days after R373's admission).

On 5/25/23 at 11:20AM, V1 (Administrator) stated, "Social services typically does the background checks and she taught me how to do them yesterday. I know this is a problem and the checks should have been done sooner but nobody else knew how to do them and I didn't know they needed to be done until yesterday."

The facility's undated policy titled, "Resident Criminal History Background Checks Identified Offender Notification Procedures" showed, "It is the policy of this facility to establish a resident sensitive and resident secure environment. In accordance with the provisions of the Nursing Home Care Act, this facility shall check the criminal history background on any resident seeking admission to the facility, in order to identify previous criminal convictions."

(C)

Statement of Licensue Violations (2 of 2)

300.610a)
300.1210b)
300.1210c)

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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 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,

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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 provide supervision to a resident with repeated falls (R55). This resulted in R55 having an two unwitnessed falls, the first fall resulted in a left femur fracture requiring surgical intervention and the second fall resulting in a right humerus fracture. The facility failed to ensure a resident at risk for falls was supervised (R59). This resulted in R59 experiencing an unwitnessed fall and fracturing her lumbar one, spinal vertebrae (lower back fracture). The facility failed to implement their fall protocol and assess a resident for falls (R40), resulting in an unwitnessed fall in R40's room. The facility failed to ensure residents with a history of falls were supervised (R34, R10) and failed to transfer a resident with a gait belt (R11). This applies to 6 of 11 residents (R55, R59, R40, R34 , R10, R11) reviewed for falls in the sample of 20.

The findings include:

1. On 05/23/23 at 9:28 AM, R55 was sleeping in a low recliner, in her room, with a sling to her right arm. R55 did not recall what happened to her arm.

The facility's Incident Report dated 12/24/22 to

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5/24/23 showed R55 had six unwitnessed falls (3/17, 3/31, 4/16, 4/24, 4/26 and 5/13).

The facility's Fall Report dated 5/19/23 showed R55 fell on 5/13/23, around 4:30 AM. A noise was heard by nursing staff in the hallway. Upon entering R55's room, R55 was observed on her right side. R55 was unable to stated how she fell when asked by V20 and V22 (CNAs - Certified Nursing Assistants). V25 (LPN - Licensed Practical Nurse) assessed R55. R55 had pain to her right shoulder. R55 was sent to the emergency room for evaluation and R55 had a fractured right shoulder (humerus).

The facility Fall Report dated 3/27/23 showed, R55 was found next to her bed on 3/17/23, around 1:30 AM (during rounds). R55 was unable to provide details of the fall. R55 was incontinent of stool and had a bruise to her right chest. R55 denied pain and her ROM (range of motion) was within normal limits, so R55 was assisted back to bed by staff. Around 8:15 AM, R55 reported pain with movement and pain medication was administered. R55 had increased confusion, incontinence, and pain. An order was obtained to send R55 to the emergency room. R55 was admitted to the hospital for a left femoral neck fracture and had surgery on her left hip.

R55's Face sheet dated 5/24/23 showed diagnoses to include, but not limited to: muscle wasting and atrophy; lack of coordination; need for assistance with personal care; generalized muscle weakness; difficulty walking; hypertension; history of falling; left femur fracture; hypothyroidism; and dementia.

R55's facility assessment dated 3/27/23 showed R55 had severe cognitive impairment; had no

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behaviors; required extensive assistance of 2 or more staff members for bed mobility, transfers, dressing, toilet use, and personal hygiene; was not steady without staff to stabilize and was frequently incontinent of urine.

R55's Care Plan initiated 10/02/22 showed R55 was at risk for falls due to deconditioning and gait/balance problems. The interventions included, "Anticipate and meet my needs; and Be sure my call light is within reach and encourage me to use it for assistance as needed. I need prompt response to all requests for assistance."

R55's Care Plan initiated 3/17/23 showed, "I had an actual fall d/t (due to) poor balance, poor communication/comprehension, and unsteady gait..." The interventions included, "Continue interventions on the at-risk plan; educate me regarding risk for falls; make sure I'm wearing non slip/gripper socks while in bed; make sure my call light is within reach... Remind me that I am in a different room and reiterate the call light use for assistance; and remind me to use my call light."

R55's Fall Risk Evaluation dated 3/23/23 showed R55 was "At Risk" with a score of 15. This document showed R55 had intermittent confusion and had 1-2 falls in the past 3 months. This document showed R55 had 1-2 predisposing disease.

R55's Incident Audit Report dated 5/13/23 showed, R55 was found lying on her right side and complained of right shoulder pain. R55 was unable to describe what happened, but denied she hit her head. R55 was transferred to the emergency room for evaluation. This document showed R55 was alert and oriented to person and

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situation and was ambulatory with an assistive device. This document showed the following predisposing factors: a wet floor, gait imbalance, impaired memory, incontinent, and recent room change.

The facility's Employee Statement dated 5/13/23 for V22 (CNA) showed, "At about 4 AM, I was doing bed checks. I heard a crash noise and went to see what it was. I saw [R55's] door almost all the way shut, which I keep them all open, so when I went in the room she was laying on the floor. She said she was trying to get up, to get dressed. Prior to this I had observed her lying in bed sleeping and had assisted her to the bathroom 3 times, previously."

The facility's Employee Statement dated 5/14/23 by V20 (CNA) showed, "Approximately 4:00 AM on 5/13 I was coming from A hall to B hall when [V22] asked me if I heard something. I had not, but I started helping her check rooms where we found [R55] on the floor. Resident was laying flat on her back and there was liquid all over the floor. Initially we thought it was urine but it turned out to be a spilled water pitcher, which is most likely the loud noise [V22] heard. [V22] stayed to assess and assist the resident while I went to get the nurse. The nurse rushed back to assess and assist. The resident wasn't able to move her right arm and was in a great deal of pain. Nurse instructed us to leave resident on the floor as she was calling the ambulance..."

R55's Hospital records dated 5/13/23 showed R55 was seen for a humeral neck fracture.

R55's Hospital X-ray report dated 5/13/23 showed, "Impacted comminuted displaced humeral head fractures as above..."

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S9999	Continued From page 8 R55's Skin Only Evaluation dated 5/13/23 at 10:55 AM, showed R55 had 4 cm x 4 cm bruise to her right deltoid; a 7 cm x 4 cm bruise to her right forearm; and a 11.2 cm x 3 cm bruise to her right wrist. R55's Orthopedic Office Visit dated 5/16/23 showed R55 was seen for discussion of her Right Proximal Humerus Fracture. This document showed that the family and orthopedic surgeon discussed R55's fracture and decided to treat in a non-operative manner. R55 was provided gentle exercises, but instructed not to lift anything over 1 pound and no over-head activities. R55's 5/13/22 Progress Note showed R55 returned to the facility at 8:25 AM with orders for pain medications and a sling to her right arm. R55 rated her pain at a 5 on a 1-10 scale (10 is worst pain ever felt). R55's 5/22/23 Progress Note showed R55's right had was very swollen with +1 pitting edema, yellow bruising was noted to right hand, sling was on her right arm, and Tylenol was given for shoulder pain. R55's right hand was elevated on a pillow. R55's 5/20/23 Progress Notes showed R55 stayed in her room for all activities and complained of right shoulder pain. On 5/24/23 at 2:47 PM, V18 (RN - Registered Nurse) said R55 fell a couple weeks ago and fractured her right shoulder. She was in the hospital for a few hours, but didn't have surgery. R55 returned to the facility with a sling on her right arm. Now she has yellow bruising, that is fading and swelling in her right hand. R55 has an appointment with Ortho next week. I wasn't here for the fall or when she fell and broke her hip. V18 stated, "I believe both falls happened on night shift." V18 said R55 was ambulatory prior to	S9999		

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the first fall in March 2023. Now R55 is mostly in a wheelchair because of the shoulder fracture. R55 can transfer with one assistance, but she can't put weight on her arm to use the walker.

On 5/25/23 at 9:16 AM, V31 (RN) said R55's confusion, impulsivity, and getting up without assistance makes her a fall risk.

On 5/25/23 at 9:48 V25 (LPN) said R55 was able to ambulate without a walker, before she fell and broke her hip. Then she needed a walker, but she wouldn't always use it. R55 insisted on wearing these "sloppy, floppy shoes." V25 continued to stated, "Sometimes she would use her call light, but that night (5/13/23) she didn't turn on her call light. I tried to encourage her to use the call light, but she'd forget and needed constant reminders. I encouraged the CNAs to leave the doors open, so they can look in on her, every time the pass by her room. That night we heard a loud noise. The CNAs went to investigate. They told me that [R55] had fallen. By the time I got in the room, she (R55) was on her back. I'm not sure what her initial position was. I think one of the CNA statements said she was on her right side. So she might have rolled over, before I got to the room. She was in obvious pain. She kept saying, "It hurts! It hurts!" and complained of right shoulder pain. There was no bruising at that time, maybe a little swelling. I called 911 and sent her out. She was in "big time" pain, so I was sure there was a fracture there. She (R55) fell around 4:00 AM, but she didn't return from the hospital during my shift. The emergency room did find a fracture in her right shoulder."

On 5/25/23 at 10:30 AM, V22 (CNA/Scheduler) said she does pick up shifts when needed. V22 stated, "I was here when [R55] fell. I was doing

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S9999	Continued From page 10 bed checks and was in another resident's room, when I heard a crash. I went in the hall to see what it was. R40 was up and moving around his room, but he hadn't fallen. I kept walking down the hall and noticed [R55's] door was almost closed and I usually keep it open, so I can keep an eye on her. When I tried to go in the room, her overbed table was up against the door, I think that's why it was almost shut. I noticed [R55] on the floor and she said she was "trying to get up and get dressed." Her water pitcher had spilled all over the floor. [R55] was lying between the two beds, across (perpendicular to the direction of the beds). The overbed table was at the end of the bed, up against the door. I think she must have gotten up, leaned against the overbed table, it moved, and she fell. I had been toileting her throughout the evening. This happened during my last rounds, around 4:00 AM. She was complaining about right shoulder pain. I yelled down for help and V25 (LPN) came to check her. [V25] told us not to get [R55] up, so I put a pillow under hear head and got a blanket to keep her comfortable. The ambulance came and took her to the hospital. She really doesn't use the call light. She thinks she can still do things on her own, but she does have a lot of shoulder pain." On 5/25/23 at 11:38 AM, V2 (DON - Director of Nursing) said she understood that the facility's efforts to prevent falls, an actual fall, and fall risk assessments must be documented in the EMR (Electronic Medical Record). V2 stated, "I understand. If it's not there, then it didn't happen. It sucks that the documentation isn't there. All falls should be documented in the facility assessments and the care plans should be resident-centered and updated with each change in condition or fall.	S9999		

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S9999	Continued From page 11 The facility's Fall Management Evaluation Policy dated 1/1/2023 showed, "It is the policy of this center to evaluate residents for their fall risk and develop interventions for prevention... Residents should be evaluated for their fall risk: on admission/re-admission to the center; following any change of status that may affect balance, mobility, or safety; following a fall; and quarterly. Risk Factors Associated with a Fall: ...Gait and balance disorders, muscular weakness (particularly of the lower extremities); dizziness or vertigo; confusion; incontinence; ... Previous falls; Current medications such as: Antipsychotics, Sedatives and hypnotics, tricyclic antidepressants, anxiolytics, and certain antihypertensives... and The use of 5 or more different medications... Procedure: Upon Admission, the nursing staff/interdisciplinary care team should determine if a resident is at risk for falls and develop appropriate interventions based on the evaluation. The goal is to prevent falls if possible and avoid any injury related to falls..." 2. On 5/23/23 at 9:49 AM, R59 was sitting up in bed and stated, "I'm not feeling the best today. I just fell blah and I don't know why. I thought today was my boyfriend's birthday and we were supposed to go out. I was worried I wasn't going to feel up to it, but the nurse told me that I have the days messed up. So, I'm going to rest today." R59's head of the bed is elevated all the way and she was leaning forward in a tripod position. R59 had oxygen in place, via nasal cannula, with long tubing coiled on the bed and on the floor beside the bed. At 12:30 PM, R59 was in her room. V5 (CNA) delivered R59's lunch tray to her room, spoke with R59 briefly and left the room. The surveyor saw R59 self-transfer from the bed to her wheelchair. R59's wheelchair was parked next to	S9999		

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the bed, between her bed and her roommates bed. R59's lunch tray was sitting on her overbed table, in front of her wheelchair. R59 stood slowly, reached down to the arm of the wheelchair with her right, shaky hand, and slowly shuffled over to the wheelchair. R59's legs and arms were shaking during the transfers and she was not picking up her feet, but shuffled them across the floor. R59 sighed loudly and stated, "Whew, that was harder than usual." R59 had two chicken legs, cheesy potatoes, and mixed veggies on her lunch tray.

On 5/24/23 at 11:07 AM, R59 was sleeping in bed with her legs hanging over the side of the bed. R50 awakened to name, but was lethargic and kept falling asleep mid-sentence. R59's pupils were pinpoint and her eyes were glassy. The surveyor asked her how she was feeling. R59 replied, "I've been better. I just feel a little off. It's hard to explain." R59 denied pain and said she wasn't sure if she had pain medication recently. R59 did not recall speaking to the surveyor on 5/23/23. R59 stated, "I talked to you? I don't remember you. I don't know what's going on with me. I thought about asking to go to the hospital last night, but I didn't." R59 fell asleep again with her legs still hanging over the edge of the bed. The surveyor walked directly to the nurses' station and reported concerns to V18 (RN). V18 said she had already called the Nurse Practitioner and she ordered a UA and some labs.

R59's Face Sheet dated 5/24/23 showed diagnoses to include, but not limited to: COPD (Chronic Obstructive Pulmonary Disease), lack of coordination, need for assistance with personal cares, generalized muscle weakness, difficulty walking, sacral pressure ulcer, wedge compression fracture of the first lumbar vertebra,

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S9999	Continued From page 13 colon cancer, lung cancer, acute respiratory failure, dysphagia, and abnormalities of gait and mobility. The Facility Fall Report dated 12/24/23 to 5/24/23 showed an unwitnessed fall on 2/3/23 at 3:45 PM. R59's facility assessment showed she had moderate cognitive impairment; had no behaviors; required extensive assistance of one staff member for transfers; and required staff assistance to stabilize. R59's EMR Kardex dated 5/24/23 showed R59 required one assist with a gait belt and walker for transfers. R59's Incident Report dated 2/3/23 showed the nurse walked by room and saw the resident was falling. R59 landed on her left hip and shoulder, but did not hit her head. R59's Hospital H&P dated 2/5/23 showed R59 fell at the facility and was having low back pain since. R59 had not been able to ambulate without assistance since she fell on 2/3/23. R59 was given pain medications (oxycodone 5 mg and toradol 30 mg). The MRI of Lumbar Spine showed: Moderate, acute to subacute vertebral body compression fracture deformity of L1 with approximately 40% vertebral body height loss, new since 1/22/2023. Pt continued to complain of lower back pain and was given fentanyl intravenously (IV). R59's undated Facility Report showed on 2/3/23 at 3:45 PM, V26 (Nurse) reported witnessing R59 falling to the floor onto the left lateral recumbent position. The resident reported she was reaching forward to try to lift something off the floor. The	S9999		

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initial assessments showed no evidence of injury or pain. However, during night shift R59's pain increased to the low back and Tylenol was not effective. The provider was notified and an X-ray was completed at the facility. The results concluded no acute fracture or dislocation seen by plain film examination. On 2/5/23 R59 was transported to the emergency room and an MRI was completed. This showed an acute fracture of the first lumbar vertebra.

R59's Safety Care Plan initiated 1/30/23 does not provide any resident specific information. The interventions for this care plan are: encourage use of prescribed assistive devices (not resident specific devices); perform safety risk evaluation on admission and as needed and upon changes in condition; and safety measures - including strategies to reduce the risk of infection, falls, injury initiated as appropriate. (This care plan does not include what R59's needs are).

R59's Fall Care Plan imitated 2/3/23 showed, "I had an actual fall with injury d/t poor balance and unsteady gait." The interventions include: continue interventions for at-risk plan; remind me to ask for assistance when wanting to pick up objects from the floor; and remind me to use my call light for assistance.

On 5/24/23 at 2:58 PM, V18 (RN) said I think R59 is feeling a little better now. I think the pain medication was getting to her when you talked to her earlier. R59 is usually pretty alert and oriented. She normally knows the date and month, but today she struggled a little with that. She's been having a lot of pain under her right breast and her lower back. I'm not sure what it's from. R59 has a wheelchair and transfers with assistance. Today she's a little more weak and

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needs more help.

On 5/25/23 at 9:36 AM, V31 (RN) said she works the night shift and R59 will get up and ambulate by herself. R59 is usually pretty steady, but had been declining and went to the hospital yesterday. She's had some changes over the last couple of days. She's been short of breath, lethargic, and confused. This morning when I tried to wake her up, she was still very confused. Normally she is pretty with it and independent. R59 is not normally lethargic and shaky. If she was, then she shouldn't have been self-transferring. She could fall and get hurt. R59 should have been a fall risk because she had a fall prior to admission to the facility.

On 5/25/23 at 9:48 AM, V25 (LPN) said R59 could be a fall risk because she has the long oxygen tubing and she could get tangled up in it. R59 would get up at night and walk out into the hallway with no oxygen or she'd walk in the bathroom with her oxygen, and that tubing is long.

On 5/25/23 at 10:30 AM, V22 (CNA/Scheduler) said R59 should not be getting up by herself. R59 needs one staff assist with a gait belt. If she's lethargic and shaking, then she could fall and get injured.

On 5/25/23 at 11:38 AM, V2 (DON) said the facility does use agency staff. R59's Care Plan should be individualized and explain the care that R59 needs. R59 has been declining this week and should not have been self-transferring. She already fell and fractured her lumbar spine. She could get hurt again if she falls.

3. On 5/23/23 at 9:32 AM, R40 was sitting in his recliner with his shoes on. R40 said he fell and

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was pointing in the direction of the window and his closet. At first R40 said he was trying to get away from the Indians. Later he said he was trying to kill some ants. R40 said he was over by his closet. There was a single chair sitting over between the window and his closet door. R40 said he was trying to kill some ants and lost his balance. He said he fell backwards onto his butt. R40 is pleasant, but confused. During this interview, V18 (RN) entered R40's room with medications. V18 confirmed that R40 was trying to kill ants, lost his balance, and fell by the closet. V18 stated, "I'm just coming in to do his follow-up assessments." V18 obtained vital signs and performed a Neuro check on R40. V18 stated, "He denies pain; his VS and neurochecks are normal, but he said his neck was hurting a little and he bumped the back of his head. I don't feel any bumps or bruises on his head." V18 finished her assessment and left the room. R40 started talking about his previous job, stood up and walked to the pictures under his TV. R40 did not use his walker. There was a rolling walker parked, next to R40. V19 (CNA) saw R40 standing and came in the room to assist him back to the recliner.

The facility fall list showed that R40 had an unwitnessed fall on 5/23/23 at 9:00 AM.

R40's Face Sheet dated 5/24/23 showed diagnoses to include: dementia, stroke, osteoarthritis, benign prostatic hypertrophy, anxiety, insomnia, unsteadiness on feet, lack of coordination, CHF (Congestive Heart Failure), respiratory failure, and fall.

R40's facility assessment dated 4/12/23 showed he had severe cognitive impairment; no behaviors; required supervision for bed mobility;

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and required setup and supervision for transfers and walking in his room.

R40's only Fall Risk Evaluation was completed on 7/22/22. This document showed R40 was to have Fall Risks completed upon admission and quarterly. This document showed that R40 was disoriented; had fallen 1-2 times in the past 3 months; required assistive devices; and had 1-2 predisposing conditions.

R40's Progress Notes dated 5/23/23 showed, "resident was in room, bending over to kill a few ants on the floor. He lost balance and sat on floor. Resident got up himself before the nurse got to the room and was sitting in the recliner." R40 reported his neck twisted and hit back on the wall. He denies pain and is able to move neck without difficulty.

On 5/24/23 at 2:47 PM, V18 (RN) said R40 was doing good. Normally he walks to the bathroom himself and gets dressed himself. He hasn't had any falls recently. R40 did not have any injuries and is doing well.

On 5/25/23 at 9:41 AM, V31 (RN) said R40 had some behaviors in the past, but had been adjusting well. He's supposed to use a wheelchair when he's out of his room. He's another resident that should ask for help, but doesn't and takes himself to the bathroom. He should ask for help, so he doesn't fall and get hurt.

On 5/15/23 at 9:48 AM, V25 (LPN) said she wasn't sure who completed the Fall Risk Assessments or how often they should be completed. R40 normally ambulates by himself, without the walker. He has a walker in his room, but the won't use it. He's supposed to.

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S9999	Continued From page 18 On 5/25/23 at 11:38 AM, V2 (DON) said the facility does use agency staff. R59's Care Plan should be individualized. V2 said the only Fall Risk she saw for R40 was dated 7/22/22, but he was supposed to have a quarterly completed. V2 observed the red font on the computer that showed R40's Fall Risk Assessment was due in March 2023 and had not been completed. These risk assessments are important to ensure we have the most up to date interventions in place for the resident's safety. 4. R10's electronic face sheet printed on 5/25/23 showed R10 has diagnoses including but not limited to dementia without behaviors, unsteadiness on feet, restlessness & agitation, hypertension, generalized anxiety disorder, and depression. R10's facility assessment dated 3/7/23 showed R10 has moderate cognitive impairment and requires 2+ staff assist for transfers. R10's care plan dated 5/16/22 showed, "Risk for injury- a bed alarm is being used while I am in bed due to I don't always use my call light for assistance and have had falls related to self-transferring. Be sure my call light is within reach and encourage me to use it for assistance as needed. I need prompt response to all requests for assistance. Make sure my alarm is in place and turned on when in use." R10's fall risk assessment dated 3/8/23 showed R10 is a fall risk. On 5/23/23 at 1:22PM, V9 (Certified Nursing Assistant) had assisted R10 onto the toilet. V9	S9999		

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told R10 she had to leave to get another staff member to help her get him up. V9 then left R10 on the toilet unattended, closed the door to his room and was gone for 3 minutes. V9 then came back into the room, told R10 she was still trying to find help and again left R10 on the toilet unsupervised. V9 stated R10 is a fall risk but he doesn't try to get up on his own and hasn't had falls that she is aware of.

On 5/25/23 at 9:53AM, V8 (Certified Nursing Assistant) stated, "Residents that are a fall risk should not be left on the toilet alone. (R10) is a fall risk so I wouldn't leave him by himself because if he tries to stand up he could fall and get injured."

On 5/25/23 at 10:38AM, V2 (Director of Nursing) stated, "(R10) is a high fall risk and he's declining so he definitely should not be left on the toilet by himself."

5) R34's electronic face sheet printed on 5/25/23 showed R34 has diagnoses including but not limited to seizures, anxiety disorder, intellectual disabilities, personal history of healed traumatic fracture, and muscle weakness.

R34's facility assessment dated 5/1/23 showed R34 has mild cognitive impairment, is a 1 person transfer assist and has had falls since her admission to the facility.

R34's nursing progress notes showed R34 has sustained 5 falls within the past 5 months.

R34's incident reports showed, "1/14/23 slid out of recliner after attempting to stand up on her own.
1/27/23 resident sitting on floor in doorway of her

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bathroom in her room with wheelchair behind her. 3/30/23 Resident was ambulating with her walker in her room and fell backwards onto her buttocks. 4/17/23 Patient found on floor in her room screaming and crying with bleeding to the scalp above left ear. Nickel sized skin tear noted with heavy bleeding. She was next to her wheelchair that had the lock on only on the right side. 5/17/23 Resident trying to self-transfer from recliner to wheelchair and slid out on floor. Urine & stool on floor."

R34's care plan dated 1/23/23 showed, "The resident has had actual falls due to gait imbalance and history of hip fracture. 1/23/23 remind me to use my call light. 4/3/23 remind and encourage me to walk even when I want to be in the wheelchair."

On 5/25/23 at 10:38AM, V2 (Director of Nursing) stated, "We discuss falls in morning meeting after any fall. The interventions we put in place depends on the situation and who it is. (R34's) sister says falling is a behavior for her and then all of a sudden she pretends she doesn't know how to walk. She knows how to call for assistance and will when she wants to. We don't have any specific interventions in place for her but we try to keep an eye on her as much as we can."

6. On 5/23/23 at 9:36 AM, V11 CNA took R11 in her wheelchair to the bathroom. V11 had a gait belt around her waist but did not apply the belt around R11. R11 was attempting to grab onto the bars in front of her and V11 brought R11 to a standing position by pulling upwards on the back of the resident's pants. V11 guided R11 to the toilet. R11 flopped down on the toilet seat. V12

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CNA walked into R11's room and V11 stated she was going to need help with peri care and the transfer. V11 and V12 provided incontinence care for R11. No gait belt was applied to R11 prior to a stand pivot transfer back to her wheelchair.

On 5/24/23 at 12:25 PM, V2 DON (Director of Nursing) stated the girls will look at the resident's kardex to see how they transfer. V2 looked in R11's electronic medical record and stated R11 was a 1-2 assist for transfers. V2 stated staff can look at the kardex and report hand off sheet for a resident's transfer status. V2 stated staff were supposed to use gait belts when transferring residents for the resident's safety. V2 stated it was not okay to use the back of a resident's pants to help them stand.

On 5/25/23 at 10:18 AM, V13 CNA stated gait belts were to be used when transferring or walking residents that need assistance. V13 stated it was for the safety of staff and residents.

The Face Sheet dated 5/24/23 for R11 showed medical diagnoses including type 2 diabetes mellitus, dysphagia, second degree burn of the trunk, major depressive disorder, anxiety disorder, atherosclerosis, hyperlipidemia, osteoporosis, macular degeneration, insomnia, muscle weakness, rectal polyp, diverticulosis, constipation, bilateral hearing loss, hemorrhage of anus and rectum, hypertension, urinary incontinence, amnesia and sleep disorder.

The MDS (Minimum Data Set) dated 4/26/23 for R11 showed severe cognitive impairment; extensive assistance of two or more people required for bed mobility, transfer, dressing, toilet use, and personal hygiene.

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S9999	Continued From page 22 The Care Plan dated 5/4/23 for R11 showed she is at risk for falls and to follow the facility's fall protocol. The activity of daily living and mobility care plan for R11 showed she has deficits related to weakness and cognition. Limited assistance of one person for transfers and extensive assistance for toileting. The facility's Gait Belt policy (1/1/23) showed, "It is the policy of this center that when the gait belt is used with a resident, the correct procedure will be followed to promote safety for the resident and employee. Apply the gait belt: Always use the gait belt when the resident requires "hands on" assistance to ambulate or transfer." (A)	S9999		