STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004261	A. BUILDING: _____ B. WING _____	C 01/23/2024

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GOLDWATER CARE BLOOMINGTON	700 EAST WALNUT BLOOMINGTON, IL 61701

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S 000	Initial Comments Complaint Investigation 2460109/IL168393	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 4 300.610 a) 300.1210 b) 300.3210 t) 300.3240 b) 300.3240 c) 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		

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. Section 300.3240 Abuse and Neglect b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act) Based on observation, interview, and record review, the facility failed to protect the residents right to be free from mental, verbal, and physical abuse by other residents; failed to timely report allegations of abuse to the State Survey Agency and Administrator; failed to thoroughly investigate abuse allegations; and failed to maintain thorough documentation of abuse allegations. These failure affects six of six residents (R8, R19, R20, R23, R18 and R9) reviewed for abuse in a sample list of 23 residents. These failures resulted in R18 verbally and mentally abusing R8, and R8 experiencing fear and tearfulness. Findings include: 1. R8's undated Face Sheet documents medical diagnoses of Cerebral Infarction, Dysarthria, Heart Failure, and Slurred Speech.	S9999		

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R8's Minimum Data Set (MDS), dated 12/29/23, documents R8 as cognitively intact.

R18's Minimum Data Set (MDS), dated 11/30/23, documents R18 as severely cognitively impaired. This same MDS documents R18 as independent in mobility. This same MDS documents R18 was assessed to have physical behavioral symptoms (such as hitting, kicking, pushing, scratching, grabbing, abusing others sexually) that occurred one to three days in the prior week of assessment.

R8's Nurse Progress Notes do not document R8's report of mental and verbal abuse from R18 on 1/8/24.

R8's Abuse Risk Assessment, dated 11/15/23, documents R8 is at risk for abuse.

R8's Careplan does not include a focus area, goal, nor interventions for being at risk for abuse.

On 1/9/24 at 12:05 PM, R8 was laying in bed in R8's room. R8 stated, "I have a problem with my roommate (R18). (R18) has something very wrong with her. (R18) is not right. (R18's) husband comes to visit her every day. (R18) has accused me before of sleeping with her husband, and I have just laughed it off. Nothing came of those other times. But last night was something different. I felt bad for (R18) before last night, and now I am just scared of her. Last night, (R18) started screaming and yelling at me saying I was sleeping with her husband. Saying I wanted her husband's big d***. I just told (R18) to shut up. (R18) was all red faced and p***** off. (R18) was seeing red. (R18) accused me of sleeping with her husband and yelled 'You b****! You

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b****! You b****!' at me. (R18) just kept yelling 'You want to hook up with him! I will get you!'. I would never do such a thing. That would be horrible. I am a tough cookie, but that really scared me. I do not want (R18) back in my room after her threatening me like that. (R18) scares me. I told (V9) Licensed Practical Nurse (LPN) last night I wanted (R18) moved. (V9) told me she let (V2) Director of Nursing (DON) know what happened. (R18) slept in here last night. I did not get much sleep because I was afraid (R18) was going to start in again, and no one would be here to help me." R8 was making good eye contact, smiling, and conversational throughout initial portions of interview. R8 did not make good eye contact, became tearful when talking about (R18), and cried through remainder of interview.

On 1/9/24 at 12:25 PM, V9, Licensed Practical Nurse (LPN), stated R8 informed V9 on the evening of 1/8/24 around 9:30 PM of R18 yelling at R8. V9, LPN, stated, "(R8) reported to me that (R18) was yelling at her and accusing her of sleeping with and having sex with (R18's) husband. (R8) never told me (R18) was using foul language. I let (V2) Director of Nurses (DON) know right then since (V2) was working the floor on the other side. I just let (V2) know. (V2) said we would talk about a possible room change in the morning. I did not assess (R8) since she did not report being physically hurt in any way. I did not report this to the physician. I just reported it to (V2)."

On 1/9/24 at 12:30 PM, R8's allegation of mental and verbal abuse was reported to V1, Administrator. V1, Administrator, was also informed of R8's statement of not wanting R18 in R8's room, and that R8 claimed R8 was scared of R18.

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S9999	Continued From page 4 On 1/9/24 at 2:08 PM, R8 was laying in bed in R8's room. R18 was sitting in the wheelchair in R18 and R8's shared room with R8. No staff were present in or around R8 and R18's shared room. On 1/11/24 at 2:00 PM, V1, Administrator, stated the abuse investigation was started immediately after being made aware of the allegation on 1/9/24. V1, Administrator, stated R8 can be tearful at times because R8 is sensitive to situations. V1 stated, "We (facility) thought it was a roommate issue until the abuse allegation was reported to me on 1/9/24. Then I knew it was more than that. (R18) does have behaviors with other residents. When (R18) has those behaviors towards her previous roommates, we (facility) move (R18) to another room. We are having a hard time finding the right fit for (R18) due to her behaviors. I do think (R18) yelled at and accused (R8), but (R8) did not cry about it when I spoke with her." V1 stated, "I do not know why (R18) was put back in (R8's) room after they were supposed to be separated. I was in the middle of my investigation. We (facility) were trying to figure out which room to place (R18). Room changes can be a real juggle when you have a high census." V1 stated the facility policy does state to separate residents who are involved in abuse allegations throughout the remainder of the investigation. 2. R19's undated Face Sheet documents medical diagnoses of Dementia, Depression, Spinal Stenosis, Osteoarthritis, Low Back Pain, Morbid Obesity, Chronic Heart Failure, and Chronic Kidney Disease Stage 4.	S9999		

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S9999	Continued From page 5 R19's Minimum Data Set (MDS), dated 12/28/23, documents R19 as cognitively intact. This same MDS documents R19 as requiring maximum assistance for bathing, dressing, toileting and bed mobility. R18's Minimum Data Set (MDS), dated 11/30/23, documents R18 as severely cognitively impaired. This same MDS documents R18 as independent in mobility. This same MDS documents R18 was assessed to have physical behavioral symptoms (such as hitting, kicking, pushing, scratching, grabbing, abusing others sexually) that occurred one to three days in prior week of assessment. R19's undated Final Incident Report to State Agency documents R19 reported an altercation with roommate (R18). "(R18) was moved." This same report does not include investigation, staff or resident interviews, or final conclusion of incident. On 1/11/24 at 2:20 PM, R19 stated, "I had an old roommate (R18) that accused me of trying to have relations with her husband. I think that was a week or so ago. (R18) got so mad one night because she really thought I was trying to take her husband that she threw a plastic cup at me. You know the ones they serve the coffee in. (R18) threw it right at me. It hit my bed and fell to the floor. (R18) then wheeled over and tried to grab my bedside table. (R18) was trying to throw my bedside table at me. (R18) was yelling all kinds of (expletive) words at me. Calling me all kinds of names. (R18) can't use her legs very well, but she is strong in her arms. I was scared of her after that. I made them (facility) move her. They (facility) just moved her across the hall and I guess she did the same thing to that lady over there."	S9999		

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On 1/11/24 at 2:35 PM, V1, Administrator, was notified of R19's allegation of abuse by R18. V1 stated she would start an investigation. V1 stated R19 has a history of making false allegations and being very verbally abusive towards staff. V1, Administrator, stated was not aware of any allegations reported by staff regarding R18 and R19.

On 1/19/24 at 9:35 AM, V1, Administrator, stated, "It was just like I thought. (R18) yelled at (R19) so we moved (R18). (R19) said (R18 threw a cup at her, but (R19) did not tell us about the bedside table being involved. (R19) has a history so I am sure she is embellishing. The investigation is finalized and reported to the State Agency. I did not have to interview anyone really since we (staff) all know about (R19's) history of making allegations. I did talk to my management team about room placement."

3. R20's MDS dated R20's MDS dated 11/28/23 documents R20 is cognitively intact.

R9's Minimum Data Set (MDS), dated 12/19/23, documents R9 is cognitively intact and exhibited verbal and physical behaviors towards others one to three days during the seven day look back period. R9's undated diagnoses list documents R9 has a diagnosis of psychotic disorder with delusions as of 1/10/24. R9's Physician/Prescriber Order Sheet, dated 1/10/24, documents R9's diagnoses of Dementia with moderate behavioral disturbances.

R9's Nursing Note, dated 12/10/23 at 12:36 AM, recorded by V42, Licensed Practical Nurse (LPN), documents R9 complained about R9's room mate (R20) not allowing R9 to turn on the

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room light during the night, and R9 requested for R9 or R20 to change rooms. There is no documentation that this request was followed up on. R9's and R20's undated census document R9 and R20 shared a room from 11/22/23 until 12/19/23, when R9 was hospitalized.

R9's Nursing Note, dated 12/19/2023 at 3:11 AM, recorded by V40, LPN, documents at 2:15 AM, a Certified Nursing Assistant (CNA) reported R9 was hitting R20 with the call light and bed control. This note documents R9 was asked what was going on and R9 reported R9 wanted the tv on and room mate (R20) kept turning the tv off. R9 denied hitting R20 and called R20 a liar. V40 instructed the CNA to bring R9 out of the room to watch tv. This note documents when V40 turned around, R9 slapped R20 on the left forearm, R9 denied hitting R20, and R9 stated R20 hit R9. This note documents R9 was transferred into a wheelchair, and while the CNA brought R9 out of the room, R9 reached over and "squeezed/pinched" R20's foot causing pain. This note documents R9 was sent to the emergency room for a psychiatric evaluation, and the local police came to the facility and obtained statements.

R20's Nursing Note, dated 12/19/2023 at 3:30 AM, documents at approximately 2:15 AM, R20 was hit several times by room mate R9 with the call light and bed controller. R20 had red marks on R20's left anterior forearm. R20 reported that R9 had turned the tv volume to 70 and refused to turn it down, so R20 turned the tv off. R9 and R20 fought over the tv for several minutes. When V42 LPN turned away, R9 loudly slapped R20's left forearm.

The facility's Initial/Final Report to the Illinois

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Department of Public Health, dated 12/22/23, documents the following: "On 12/19/23 at 3:30 AM, (R9) was physically and verbally aggressive towards room mate, (R20). (R9) was yelling at (R20) after (R20) asked (R9) to turn the television (tv) volume down causing (R9/R20) to argue. (R20) reported that (R9) hit (R20's) left forearm with the remote and call light. (R9) was witnessed to pinch (R20's) foot. (R20) had a red mark and complaints of "stinging" to the left forearm. The Nurse (V40 Licensed Practical Nurse(LPN)) intervened and (R9) was sent to the hospital."

This investigation does not document when this incident was reported to V1, Administrator, who reported the incident to V1, and the time it was initially reported to the state survey agency.

On 1/16/24 at 12:46 PM, V40, Licensed Practical Nurse/LPN stated V40 recalled R9's/R20's incident on 12/19/23. V40 stated V41, Certified Nursing Assistant/CNA, came running up the hall and told V40 to immediately go to R9's room since R9/R20 were arguing over the tv. V40 stated R9 was sitting in a recliner next to R20, and R20 reported R9 took R20's call light and started whipping R20 with it. V40 stated V40 turned around to get the CNAs and heard a "smack." V40 stated R9 had smacked R20 on the arm, and R20's arm had a red mark. V40 stated R9 transferred into a wheelchair, and while removing R9 from the room, R9 grabbed and squeezed R20's foot "as hard as she could." V40 stated that was the first time V40 has observed R9 to be abusive to R9's room mates. V40 stated V40 notified an unidentified nurse manger on call, and the nurse manager is responsible for reporting the incident to V1, Administrator.

On 1/16/24 at 1:33 PM, R9 stated R9 used to

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reside with another resident who was a "troublemaker." R9 stated, "It's my tv", and R9 had the tv down low. R9 stated there wasn't any physical hitting, it was all verbal, and nurses and CNAs witnessed the incident. R9 stated anyone around could hear the commotion. R9 stated R9 isn't saying R9 is innocent, "she mouthed off and I (R9) mouthed back." R9 stated the staff knew R9 wanted a different room mate.

On 1/16/24 at 1:44 PM, R20 stated R20 had a room mate who "physically attacked me." R20 stated R9 woke R20 up with the tv volume at 70, and R20 told R9 to turn the tv volume down. R20 stated R9 came over to R20's bed and hit R20's hand with the bed remote that caused bruising. R20 stated R20 called for staff and R9 continued to hit R20 as the staff removed R9 from the room. R20 stated the staff witnessed the incident. R20 stated R20 did not feel afraid of R9, but R20 felt like R20 could not defend herself.

On 1/16/24 at 12:32 PM, V42, LPN, stated V42 recalls the night of 12/10/23, R9 had turned on R9's call light and was mad because R20 was upset with R9 for turning on the room light to go to the bathroom. V42 stated V42 explained to R20 that R9 needed the light on to be able to get to the bathroom, and R9 wanted R20 to be moved out of R20's room. V42 stated R9 does not like people in R9's room. V42 stated V42 was able to calm both R9 and R20 down, both R9/R2 went to bed, and V42 passed onto the dayshift nurse that R9 wanted R20's room moved. V42 stated V42 is not sure who takes care of resident room changes. V42 confirmed R20's room was not changed until after R9's/R20's incident on 12/19/23.

On 1/16/24 at 1:06 PM, V41, CNA, stated R9 has

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had many conflicts with roommates, "You have to run to her (R9's) room when you hear something." V41 stated V41 witnessed R9 with the bed control "slapping" R20's left arm and as R9 was removed from the room, R9 grabbed R20's leg and banged R9's fist on R20's leg. V41 confirmed R9's actions towards R20 were intentional and not an accident.

On 1/16/24 at 3:02 PM, V2, Director of Nursing (DON), stated abuse allegations should be reported to V1 within an hour, and when V2 is notified of incidents, V2 asks the staff if V1 has been notified. V2 stated if V1 has not been notified, then V2 reports the incident to V1. V2 did not recall if V2 was the nurse manager who was notified of R9's/R20's 12/19/23 abuse allegation.

On 1/16/24 at 3:21 PM, V1, Administrator, was asked when V1 was notified of R9's/R20's abuse allegation and who reported the allegation to V1. V1 stated it would have been reported to V1 immediately after the incident, and V1 thought V2, Director of Nursing ,reported the incident to V1. V1 did not provide a date and time that this allegation was reported to V1 and IDPH, as requested. V1 stated the initial and final report of this allegation was submitted as one report to IDPH. V1 confirmed the facility's initial/final report of R9's/R20's abuse allegation is dated as 12/22/23, three days after the incident. V1 stated staff are expected to immediately report allegations of abuse to V1, and then V1 submits the initial report to IDPH "right away." V1 confirmed allegations of abuse are to be reported to IDPH within two hours, and confirmed the facility's investigation of R9's/R20's abuse allegation does not document who reported the incident and when this incident was reported to V1. At this time, V1 was requested to provide

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documentation confirming submission of the initial report to IDPH. At 4:02 PM, V1 confirmed all of the documentation of R9's/R20's abuse allegation has been provided. V1 stated V1 is still looking for a confirmation receipt of submission of R9's/R20's initial report, and V1 should have an electronic mail confirmation that documents the facility submitted the report through the IDPH electronic reporting system.

On 1/17/24 at 9:15 AM, V1 stated V1 located the initial report for R9's/R20's abuse allegation and V1 had marked the "wrong box" for the report that was previously provided. V1 provided the report to IDPH Regional Office, dated 12/19/23, but there is no documented submission time. V1 stated this initial report was sent to IDPH on the morning of 12/19/23. V1 stated V1 has been unable to locate a confirmation receipt of submission to IDPH for this report.

On 1/17/24 at 12:38 PM, V6, Assistant DON, stated V6 was the nurse manager on call who was notified of R9's/R20's incident during the "early morning" of 12/19/23. V6 was unable to give a time of when V6 was notified. V6 stated V6 reported the incident to V1 immediately after V6 was notified.

4. R23's MDS, dated 11/13/23, documents R23 has severe cognitive impairment. R23's Social Service Note, dated 8/17/2023 at 1:20 PM, documents R23's room was moved after staff determined the room was "unsafe" due to room mate's (R9) behavior. R23's and R9's undated census document R23 and R9 shared a room from 7/19/23 until 8/1/23.

On 1/16/24 at 12:46 PM, V41, CNA, stated on an unidentified date, V41 heard screaming from

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R9's/R23's room. V41 went to the room, R9 was yelling at R23, and R9 picked up R9's walker and hit R23's leg with the walker. V41 stated V41 went to get V3, Registered Nurse. V41 returned to the room, and R9 hit R23's leg again with the walker. V41 stated R9's actions were intentional and not an accident. V41 stated V41 was present when V3 called V1 to immediately report this incident. V41 stated R23 was moved to another room that night and they never shared a room again.

On 1/17/24 at 11:01 AM, V49, Social Services Director, referring to 8/17/23 note, stated R23 would fall asleep in R23's chair, and R9 would wake R23 to go to activities. V49 stated staff felt R9's behavior of throwing a deck of cards towards R23 was unsafe for R23 to remain R9's room mate. V49 was unsure who the staff were that witnessed this incident, and stated the cards did not hit R23, they landed in front of R23's wheelchair. V49 stated, "This incident was discussed in morning meeting, with (V1) present, and we determined (R23) would not be moving back in with (R9)." V49 stated the incident happened on 8/1/23, the day that R23 changed rooms.

There are no documented abuse investigation files and reports for these incidents.

On 1/17/24 at 1:25 PM, V1 stated V1 was aware of the incident of R9 throwing a deck of cards at R23. V1 stated R9 threw the cards to get R23's attention. V1 confirmed this incident was not reported to IDPH, and the facility did not have an abuse investigative file for this incident. V1 stated because R9 has Dementia, R9's act was not done with the "intent to harm", but done to get R23's attention. V1 stated V1 did not consider this

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to be an abuse allegation.

On 1/18/24 at 9:50 AM, V1 stated V1 was not aware of an incident where R9 used a walker to hit R23's leg. V1 confirmed that is something that would have been reported and investigated, and V1 stated V1 will follow up on this information. V1 did not provide any additional documentation as requested for the card incident.

The facility's Abuse Prevention and Reporting - Illinois policy revised 4/14/22 documents: "Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm." "Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator." "Reports should be documented and a record kept of the documentation." "All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and

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S9999	Continued From page 14 misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury; or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with State law through established procedures." (B) 2 of 4 300.610 a) 300.1010 h) 300.1210 b) 300.1210 d)3) 300.1220 b)3) 300.3240 a) 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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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 resident's medical record.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the

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nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

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 assess a resident with previous medical history of Respiratory illness and hospitalizations who was in acute respiratory distress, and failed to notify the Physician timely of a change in respiratory condition for a resident. These failures resulted in R17 experiencing respiratory distress for a period of 15 hours, with a low oxygen level, and yelling out to staff of being unable to breathe before R17 was transferred to a local hospital in respiratory distress. This failure affects one (R17) of three residents reviewed for a change in condition.

R17 experienced respiratory distress for a period of 15 hours, with a low oxygen level and yelling

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S9999	Continued From page 17 out to staff being unable to breathe. R17 was eventually transferred to a local hospital with respiratory distress. Findings include: Facility Assessment, dated 7/30/23-1/30/24, documents residents who are experiencing acute care episodes or exacerbations of diseases are immediately given a full report to physician and follow their orders. R17's undated Face Sheet documents an admission date of 10/17/23, with medical diagnoses of Chronic Obstructive Pulmonary Disorder (COPD) with Acute Exacerbation, Metabolic Encephalopathy, Diabetes Mellitus, Acute and Chronic Respiratory Failure with Hypoxia, Protein Calorie Malnutrition, Hepatic Failure, Heart Failure, Severe Sepsis with Septic Shock, and Anemia. R17's Minimum Data Set (MDS), dated 11/7/23, documents R17 as moderately cognitively impaired, and requires moderate assistance from staff for dressing, personal hygiene and mobility. This same MDS documents R17 does not have a medical diagnosis of Anxiety. R17's Care plan intervention, dated 10/17/23, instructs staff to monitor for difficulty breathing on exertion. This same care plan did not include a focus area, goal, nor interventions for Oxygen therapy. R17's current Electronic Medical Record (EMR) shows the last set of vital signs obtained for R17 was on 12/12/23 at 12:11 PM, and were within normal limits. This same EMR documents R17	S9999		

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had a previous hospitalization from 10/20/23 to 11/2/23, with diagnoses of Acute on Chronic Respiratory Failure and Sepsis.

R17's Physician Progress Note, dated 12/11/23, documents R17 had a "moderate cough productive of clear sputum. Lungs clear bilaterally with no rales, rhonchi or wheezes." This same note documents a physician order for Mucinex 600 milligrams (mg) twice daily.

R17's Physician Order Sheet (POS), dated December 2023, does not document a physician order for Mucinex 600 mg twice daily.

R17's Medication Administration Record (MAR), dated December 2023, documents R17 was administered one puff of scheduled Fluticasone-Salmeterol Inhaler 500-50 micrograms (mcg)/ACT on 12/12/23 at 4:00 PM, and 12/13/23 at 8:00 AM per physician order. This same MAR documents R17 was administered Ipratropium/Albuterol inhalation solution 0.5-2.5 milligrams (mg) per 3 milliliters (ml) on 12/12/23 at 8:00 PM and on 12/13/23 at 8:00 AM per physician order. This same MAR documents R17's Lisinopril 5 mg and Atenolol 50 mg were both held at 7:43 AM on 12/13/23 due to 'low blood pressure.'

R17's Nurse Progress Notes document:

-12/12/23 at 6:21 PM, documents "At 5:35 PM (R17) complained of difficulty breathing during wound care. Care was paused and (V22, Licensed Practical Nurse/LPN) was notified of (R17's) complaint. At 6:00 PM, (R17) was reassessed due to pale color and increased work of breath noted upon exhalation. At 6:05 PM, a second notification via (V27, Certified Nurse

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Aide/CNA) was sent to (V22, LPN). At 6:08 PM (R17) was reassessed with oxygen saturation at 77%. Nasal canula in place and functioning properly. (V22, LPN) notified at shift change and at bedside. (V22, LPN) administering treatment at 6:11 PM. Will continue to monitor."

-12/13/23 at 4:52 AM, documents "Every hour (R17) hollers out very loudly for help. Does not use the call light. (R17) says he can not breathe. (V22) tried to educate (R17) that if he can holler that loud, he is breathing fine. (R17) was given breathing treatments whenever the time was appropriate. Despite (V22) trying to educate (R17), he continued to holler out. It is my estimation that (R17's) problem is much more anxiety related than physical."

-12/13/23 at 7:43 AM, documents R17's Lisinopril 5 milligrams (mg) (blood pressure medication) and Atenolol 50 mg (blood pressure medication) was held due to low blood pressure.

-12/13/24 at 9:14 AM, documents, "Weekly wound rounds completed this shift. (R17) not well tolerated. (R17) complained of difficulty breathing. Oxygen saturation was 88% on 3 Liters per Nasal Canula with heart rate of 74. Pulse oximetry kept in place during wound assessment. Decreased oxygen saturation noted during care, while rolling in bed from Left to Right. Message sent to (V30, Nurse Practitioner) via voice to voice call, advising change of condition and request for breathing treatment to be administered as needed. Power of Attorney (POA) advised to call back via voice message. Will continue to monitor."

-12/13/23 at 9:47 AM, documents, "Received orders from (V30) Nurse Practitioner to send

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(R17) to emergency room for further evaluation and treatment."

R17's hospital records, dated 12/13/23-12/15/23, document R17's admission diagnoses as Sepsis, Loculated Pleural Effusion, and Empyema. This same hospital record documents R17's Hospital Emergency Room note, dated 12/13/23, documents, "(R17) presents to emergency room from facility complaining of worsening shortness of breath and cough. Alert and oriented, ill-appearing, in mild distress with wheezes, rhonchi and crackles noted bilaterally. (R17) was chronically on 3 Liters (L) of Oxygen and in the emergency department was placed on 6 L of Oxygen. (R17) had a blood pressure of 70/50 and was given a fluid bolus and Antibiotics. (R17) Chest X-Ray reveals bilateral infiltrates. (R17) was transferred to the Intensive Care Unit (ICU) for Septic Shock and Acute on Chronic Respiratory Failure. (R17's) CT (Computerized Tomography) of chest showed Left sided Empyema. (R17) was transferred to Critical Care Unit (CCU) in critical condition."

These same hospital records documents, "(R17's) Final diagnosis and diagnosis during hospitalization of Septic Shock from Left Sided Loculated Pleural Effusion, Bilateral Pneumonia, Acute on Chronic Hypoxic Respiratory Failure secondary to Left Sided Loculated Pleural Effusion, Concern for Bacterial Pneumonia, Concern for Acute Adrenal Insufficiency, Acute Kidney Injury from Septic Shock, Hyperkalemia, Chronic Normocytic Anemia with Iron and Folate Deficiency, Chronic Stage III-IV Sacral Wound with history of Osteomyelitis and 54 millimeter (mm) Abdominal Aortic Aneurysm. (R17) was made comfort care on 12/15/23 at 12:45 AM and passed away at 12:52 AM." These same hospital

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records document R17's cause of death as "Septic Shock from Left Sided Empyema/Loculated Pleural Effusion".

R17's Computerized Tomography (CT) of chest/pelvis and abdomen results, dated 12/13/23, documents, "Impression: Findings suspicious for Empyema on the Left side, Emphysematous changes in lungs, Bilateral lower lung zone infiltrates, Right Pleural Effusion, 54 millimeter (mm) Infrarenal Abdominal Aortic Aneurysm."

On 1/17/24 at 9:30 AM, V47, Minimum Data Set (MDS)/Careplan Coordinator, stated the designated department head would add in careplans for the resident need, and V47 reviews the entire careplan afterwards as a back up system. V47 stated any resident who receives Oxygen should have a separate Oxygen careplan. V47 stated the interventions should include keeping the head of bed raised, following the physician order for Oxygen use, obtaining Oxygen saturation levels every shift, and monitoring for signs and symptoms of low Oxygen levels.

On 1/11/24 at 1:10 PM, V22, Licensed Practical Nurse (LPN), stated V22 was R17's nurse on the evening of 12/12/23 and early morning of 12/13/24. V22 stated, "(R17) was always complaining he couldn't breathe. All the time. (R17) would not use his call light he would just bang on the table and yell out. That night (12/13/23), (R17) was at it again. (R17) was yelling loud enough you could hear it down the hall. I went into (R17's) room and told him he can't be in that much respiratory distress since he had enough lung power to yell that loud. (R17) had already had whatever medication was

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ordered to help him breathe. (R17) just needed to calm down. (R17) was short of breath from yelling out. We (staff) boosted (R17) up in bed. I personally believe that (R17) had anxiety issues. (R17) doesn't have that diagnosis but I know that is the problem. (R17) could breathe just fine. I know this since (R17) was yelling so loud. You can't yell that loud and be in respiratory distress at the same time. (R17) yelled out all the time. (R17) had just gotten out of the hospital from his respiratory problems. I am sure the Physician already knew (R17) had breathing problems, so there would be no need for me to call him. What am I supposed to do, call the doctor in the middle of the night and tell him (R17) couldn't breathe? I am sure the doctor would love that since he already knew that was a common complaint of (R17's). I don't remember getting any vital signs. I didn't listen to (R17's) lungs. There was no need to. (R17) was just having anxiety not breathing problems. The vital signs would be in (R17's) Electronic Medical Record (EMR). That is where the CNA's document them. If the vitals are not in (R17's) EMR then they were not done."

On 1/11/24 at 1:30 PM, V19, Wound Nurse, stated V19 was providing wound care to (R17's) roommate on the evening of 12/12/23. V19 stated R17 was yelling out saying he couldn't breathe. V19 stated R17 would normally yell out in place of using his call light. V19 stated, "That night was different. (R17) was very short of breath. (R17) skin was dusky looking, and he just didn't look right. There was something more than his normal yelling. You could tell (R17) really couldn't breathe. I had (V27, CNA) working with me so I stayed with (R17) and sent (V27) to go get (R17's) nurse. (V27) returned to (R17's) room a few minutes later, but (V22) (R17's) nurse never showed up. We (V19, V27) stayed with

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(R17) for ten more minutes or so. I sent (V27) again to get (V22), but that time neither (V27, CNA, V22, LPN) of them returned. So, I called out into the hall and asked another CNA to sit with (R17) and I went to get (V22) myself. (V22) was sitting at the nurses desk. When I explained to (V22) LPN what was going on with (R17), (V22) exclaimed 'If (R17) can yell, he can breathe. It is just behaviors.' I found a pulse oximeter and obtained (R17's) oxygen saturation. It was 77%. (R17's) skin was still dusky, and he still didn't look good. I told (V22) LPN (R17) was not stable, but he did not take it seriously. I even checked the Pulse Oximeter on my own finger to make sure it was working properly. It was. There was nothing wrong with the machine. There was something wrong with (R17). At that point, (V22, LPN) came in and assessed (R17), and I left the situation. The next morning, I went in to provide wound care to (R17) again, and the same situation happened again. I really thought (V22, LPN) would have sent (R17) out the night before because of his change in condition, but (R17) was still in his room. (R17) was still having trouble breathing so I called (V30, Nurse Practitioner) to ask to get (R17) sent in to the emergency room. (V30) called back and gave the order to send (R17) to the emergency room."

On 1/17/24 at 12:10 PM, V30, Nurse Practitioner (NP), stated the expectation of the provider is for the facility to ensure all of the Physician orders are completed and non-pharmacological interventions are carried out before calling for new orders. V30, NP, stated after all of the existing orders and non-pharmacological interventions are completed, then the facility should call the provider to obtain new orders. V30 stated R17 did have an established medical history of co-morbidities with medications in place

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to maintain R17 as stable. V30 stated, "Early intervention is the best way to prevent decline in health. When the facility delayed medical treatment, assessments/monitoring or notification to the provider then that would have caused harm (medical decline) to (R17). As it sounds, (R17) was having respiratory distress that was not addressed. The facility should have notified the provider of (R17's) worsening condition." V30 stated V30 would have sent R17 to the emergency room for further clinical support on the evening of 12/12/23 when staff initially noted R17's change in condition. V30 stated, "It is standard for nurses to hold blood pressure medications if a resident's blood pressure is low, but you have to look at the bigger picture. (R17) had been in respiratory distress all night which could contribute to his low blood pressure. That should have been reported as well."

On 1/23/24 at 10:10 AM, V6, Assistant Director of Nurses (ADON)/Licensed Practical Nurse (LPN), stated R17 was seen by V39, Medical Director/Physician, on 12/11/23. V6 stated V39's Physician Progress Note that documented a new order for Mucinex was 'overlooked'. V6 stated facility does not review the physician progress notes, only the written orders.

The facility policy titled 'Physician-Family Notification-Change in Condition', revised 11/13/18, documents the facility will inform the resident, consult with the resident's physician or authorized designees such as Nurse Practitioner, and if known, notify the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental or psychosocial status and/or a need to alter treatment significantly and/or a decision to transfer or discharge the

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S9999	Continued From page 25 resident from the facility. (A) 3 of 4 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)1) 300.1210 d)2) 300.1210 d)3) 300.1210 d)5) 300.1220 b)3) 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	S9999		

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each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

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3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Based on observation, interview, and record review, the facility failed to provide treatment and services to prevent worsening of a residents (R3) pressure ulcer. The facility also failed to assess, monitor, and follow physician orders for resident's wounds. These failures affect two (R3, R14) out of four residents reviewed for Pressure Ulcers in a sample list of 23 residents. These failures resulted in a deterioration R3's Stage IV Sacral Pressure Ulcer with grey tissue, foul odor and substantial amount of drainage from the wound.

These requirements are not met as evidenced by:

Findings include:

1. R3's undated Face Sheet documents an admission date of 11/14/23. This same Face Sheet documents R3's medical diagnoses of Spondylosis of Lumbar Region without Myelopathy or Radiculopathy, Syndrome of Inappropriate secretion of Antidiuretic Hormone, Anxiety, Depression, Disorders of the eyelids,

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Exposure Keratoconjunctivitis, Legal Blindness, Seizure Disorder, Waldenstrom Macroglobulinemia, Methicillin Resistant Staphylococcus Aureas MRSA), Pressure Ulcer of Sacrum Stage IV, Right Femur Fracture and Obstructive and Reflex Uropathy. R3's Minimum Data Set (MDS) dated 12/27/23 documents R3 as cognitively intact. This same MDS documents R3 as legally blind and requiring maximum one person assist for toileting, upper and lower body dressing and moderate assistance for chair/bed to chair transfer.

R3's Hospital Wound Assessment Summary, dated 11/13/23, (day before discharge) documents R3's Stage IV Coccyx Pressure Ulcer as having 76-100% red granulation tissue, 1-25% yellow slough, moderate amount of drainage and measuring 18.5 centimeters (cm) long by 10.5 cm by 4.2 cm including wound at Right lower edge of main Coccyx wound measuring 7.0 cm long by 3.8 cm wide by 0.1 cm deep. R3's Hospital Discharge Record, dated 11/14/23, documents a physician order to place a negative pressure wound vacuum (wound vac) set at 125 millimeters (mm) Hg (Mercury) continual negative pressure over R3's Coccyx wound every three days and as needed.

R3's Admission Observation, completed 11/15/23, documents, "Pressure wound present on Coccyx. See Wound Nurse Wound Assessment." This same assessment does not document wound description or measurements of R3's Coccyx Pressure Ulcer. R3's Pressure Ulcer Risk Assessment dated 11/15/23 documents R3 is at risk for Pressure Ulcers.

R3's Wound Assessment Details Reports, dated 11/14/23, 11/22/23, 11/29/23, 12/4/23, 12/7/23,

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S9999	Continued From page 29 12/26/23, and 1/8/23, all document R3's Stage IV Coccyx Pressure Ulcer as "100% beefy red", having no drainage and measuring 14.0 centimeters (cm) long x 4.0 cm wide by 0.0 cm deep. R3's Careplan, dated 11/20/23, instructs staff to monitor pressure ulcer on Coccyx and follow physician orders for treatment. This same careplan does not include a focus area, goal nor interventions for R3's Stage IV Pressure Ulcer prior to 11/20/23. R3's Wound Evaluation and Management Summary documents the folllowing: - 11/16/23 documents an initial assessment of R3's Stage IV Coccyx Pressure Ulcer as having heavy serosanguinous drainage measuring 14.0 cm long x 15. 0 cm wide x 4.0 cm deep. This same evaluation documents physician orders to start Vitamin C 500 milligrams (mg) twice daily, Multivitamin daily, Zinc Sulphate 220 mg daily for 14 days, protein supplement three times per day, Registered Dietician (RD) consultation, upgrade offloading chair cushion, reposition per facility protocol and refer (R3) to plastic surgeon for flap closure. - 12/13/23 documents V32, Wound Physician, did not assess R3's Right Upper Lateral Leg partial thickness venous wound due to a recent wound related hospitalization(currently in the hospital). - 1/3/24 documents V32, Wound Physician, is signing off (case) due to R3 to see offsite wound clinic. R3's Electronic Medical Record (EMR) does not document R3 being seen by a wound clinic. R3's Medication Administration Record (MAR), dated November 2023, does not include physician orders for Vitamin C 500 milligrams	S9999		

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(mg) twice daily, Multivitamin daily, Zinc Sulphate 220 mg daily for 14 days, protein supplement three times per day, Registered Dietician (RD) consultation, upgrade offloading chair cushion, reposition per facility protocol and refer (R3) to plastic surgeon for flap closure.

R3's MAR, dated December 2023, documents a physician order starting 12/23/23 for a daily Multi Vitamin and Vitamin C 500 milligrams (mg) twice daily. The same MAR does not include physician orders for Zinc Sulfate 220 mg daily or protein supplement three times per day.

R3's Treatment Administration Record (TAR), dated November 2023, a physician order starting 11/16/23 and ending on 11/18/23, to apply wound vacuum to (R3's) Coccyx wound. Apply oil emulsion over exposed bone medially prior to placing sponge for wound vac. Setting 125 mmHg continuous. Change every three days. This treatment was documented as not completed on 11/16/23 and 11/18/23, with a note referring to 'see nurse progress note'. This same TAR documents a physician order starting and ending on 11/17/23, and again starting 11/19/23 and ending on 11/30/23, documents "apply saline moistened gauze covered with absorbent pad to (R3's) Sacral Stage IV Pressure Ulcer daily". This same TAR does not document R3's Sacral Pressure Ulcer dressing change as being completed on 11/19/23, 11/21/23, 11/22/23 and 11/24/23. This same TAR does not document treatment orders for R3's Stage IV Pressure Ulcer wound from 11/14/23-11/16/23.

R3's Nurse Progress Notes do not document R3's physician ordered wound vac being applied or refused nor use of alternate saline dressing as ordered.

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On 1/10/24 at 10:45 AM, V19, Wound Nurse, completed wound care for R3's Stage Four Pressure Ulcer on Coccyx and R3's Right outer calf wound. V18, Certified Nurse Aide (CNA), assisted with positioning of R3 during wound care. R3's incontinence brief, Coccyx dressing, incontinence pads, mattress, and sheet R3 was laying on, were completely saturated with light yellow liquid. V19, Wound Nurse, used disinfectant wipes to attempt to clean R3's bed mattress due to linens being excessively saturated. R3's Coccyx bandage was grossly saturated with pieces of cotton on inside of bandage separated into ball shaped pieces. R3's Coccyx bandage was not dated or initialed. R3's bed linens were completely saturated from R3's upper shoulders to below feet. R3's Coccyx Stage Four Pressure Ulcer was a large open area with undermining at edges covered with grey slough, copious amount of brown/grey drainage and had very foul odor that permeated the room.

On 1/10/24 at 11:00 AM, V19, Wound Nurse, stated, "(R3) should never have been left in this mess." V19 also stated, "We (facility) are trying to heal (R3's) wounds not make them worse. I just can't believe what condition (R3) has been left in. I can not tell you when (R3's) Coccyx dressing was changed last because it was not dated. Some of that drainage was from (R3's) Coccyx wound, but I believe most of it was from (R3's) Right outer calf and other weeping areas on (R3's) lower legs. (R3) has Methylicillin Resistant Staphylococcus Aureus (MRSA) in her Coccyx wound already. That is why (R3) is on contact isolation precautions. I am going to have to do some training with the staff."

On 1/17/24 at 8:25 AM, V48, Receptionist, stated

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S9999	Continued From page 32 R3 had an appointment at the local wound clinic on 11/20/23, but did not attend that, and has her next appointment scheduled for 1/25/24. V48 stated R3 has not been to any other wound clinic. On 1/17/24 at 10:30 AM, V19, Wound Nurse, stated R3 has first appointment at an offsite wound clinic on 1/25/24. V19 stated R3 admitted to facility on 11/14/23, had first wound assessment on 11/14/24, and was seen by V32, Wound Physician, on 11/16/23, 11/30/23, and 12/7/23. V19 stated V32 did not see R3 on 12/13/23, due to R3 being hospitalized from 12/11/23-12/22/23 for R3's wound infection. V19 stated, "(V32) signed off on (R3) on 1/3/24 due to (R3) was going to start going to the wound clinic. (V32's) last time assessing (R3's) wounds was 12/7/23. I have assessed (R3's) wound weekly since then when (R3) was not in the hospital. (R3) has been in the hospital most of that time so there are some assessments that are not done. I did the assessments, but did not measure (R3's) Coccyx wound. I just leave the same measurements in the assessments every week because you have to put something in for the computer system to allow you to move on to the next date. I should have really assessed (R3's) wounds on the weeks that (V32) Wound Physician wasn't there to do it." V19, Wound Nurse, stated R3's Coccyx wound was not 100% beefy granulation as documented. V19, Wound Nurse, stated R3's Coccyx wound 'appears larger' and no beefy granulation tissue was present. V19, Wound Nurse, stated, "(R3's) Coccyx wound appears worse to me. There is no granulation tissue. All the tissue we can see is grey. It has a foul odor and there is a substantial amount of drainage. This is much worse than when (R3) came back from the hospital."	S9999		

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S9999	Continued From page 33 2. R14's undated Face Sheet documents an admission date of 9/9/23, with medical diagnoses list includes Wedge Compression Fracture of Second Lumbar Vertebrae, Anxiety, Hypertension, Urinary Tract Infection (UTI). R14's Minimum Data Set (MDS), dated 10/3/23, documents R14 is cognitively intact. This same MDS documents R14 requires maximum assistance for bed mobility, transfers and bathing. R14's Pressure Ulcer Risk Assessment, dated 12/30/23, documents R14 is at moderate risk of obtaining a pressure ulcer. R14's Care plan documents R14 requires one assist for bed mobility. This same care plan does not include a focus area, goal, nor interventions for R14's Coccyx pressure ulcer. R14's Physician Order Sheet (POS), dated 9/30/23, to apply a Hydrocolloid dressing over R14's Coccyx area every three days and as needed. R14's Treatment Administration Record (TAR), dated January 2024, documents a physician order starting 9/30/23 to apply a Hydrocolloid dressing over R14's Coccyx area every three days and as needed. R14's Wound Assessment Details Report, dated 1/2/24, documents R14's Coccyx Pressure Ulcer as Stage II measuring 0.3 centimeters (cm) long by 0.3 cm wide by 0 depth. R14's Wound Assessment Details Report, dated 1/10/24, documents R14's Coccyx Pressure Ulcer as Stage II measuring 1.0 centimeters (cm) long by 2.0 cm wide by 0 depth.	S9999		

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S9999	Continued From page 34 On 1/10/24 at 9:10 AM, V19, Wound Nurse, completed wound care for R14's Coccyx wound. R14 did not have a previous dressing in place to Coccyx. R14's Coccyx area showed three nickel sized open areas that were red with small amount of clear drainage. Several small tinted areas noted on inside of R14's incontinence brief located directly in line with where R14's open wounds would come in contact. V19 cleansed areas then applied Zinc cream and bordered foam over R14's open wounds. On 1/10/24 at 9:30 AM, V19, Wound Nurse, stated, "(R14) had a Stage One Pressure Ulcer on her Coccyx. Now it looks like it has opened in a few small spots. So that would make it a Stage Two. I hate to see that (R14's) wound has gotten worse, but hopefully we can get it heading back the right direction. We (facility) have been out of the Hydrocolloid dressings so I have been putting on Zinc and foam until we get our supply truck in on Wednesday. I know I put on the wrong dressing, but that is only because we (facility) do not have the ones ordered by the Physician. We (facility) have standing orders but those are to be used if there is not an order in place. (R14) does have an order, we are just out of the supplies." The facility policy titled 'Pressure Injury and Skin Condition Assessment', revised 1/17/18, documents the resdient's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches and goals for care. (B) 4 of 4	S9999		

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S9999	Continued From page 35 300.610 a) 300.1010 h) 300.1210 b) 300.1210 c) 300.1210 d)3) 300.1210 d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies 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	S9999		

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care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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 observation, interview, and record review, the facility failed to respond to a residents call light in a timely manner; failed to thoroughly investigate and provide increased supervision to prevent a residents fall; failed to complete fall risk assessments and implement fall interventions; failed to timely report a fall with head injury to the physician; failed to complete post fall assessments; and failed to complete post fall

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neurological assessments for a resident. These failures affects three (R3, R7, R21) out of four residents reviewed for falls in a sample list of 23 residents, resulting in R3 falling and sustaining a femur fracture.

Findings include:

1. R3's Minimum Data Set (MDS), dated 12/27/23, documents R3 as cognitively intact. This same MDS documents R3 as legally blind and requiring maximum one person assist for toileting, upper and lower body dressing and moderate assistance for chair/bed to chair transfer. R3's undated Face Sheet documents Medical diagnoses of Spondylosis of Lumbar Region without Myelopathy or Radiculopathy, Syndrome of Inappropriate secretion of Antidiuretic Hormone, Anxiety, Depression, Disorders of the eyelids, Exposure Keratoconjunctivitis, Legal Blindness, Seizure Disorder, Waldenstrom Macroglobulinemia, Methicillin Resistant Staphylococcus Aureas MRSA), Pressure Ulcer of Sacrum Stage IV, Right Femur Fracture, and Obstructive and Reflex Uropathy.

R3's Careplan intervention, dated 11/18/23, documents R3 requires prompt response to all requests, follow facility fall protocol. R3's Fall Risk Assessment, dated 12/22/23, documents R3 is at risk for falls.

R3's Fall Investigation, dated 1/1/24, documents R3 had an unwitnessed fall in R3's bathroom at 2:20 AM on 1/1/24. This same fall investigation documents R3 was cognitively intact and call light had been activated prior to fall. This fall investigation documents R3 complained of pain in Right Shoulder and Groin area. R3's fall

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investigation documents, "(R3) stated she had to use the restroom and did not want to wait for help." This same fall investigation documents "per (R3) request, (R3) sent out to emergency room for evaluation due to pain that could not be controlled with current pain medication orders."

R3's X-Ray of Right Hip report, dated 1/1/24, documents, "Clinical indication: Right Hip pain after fall, possible fracture. Impression: Remote fractures of the Left Superior and Inferior Pubic Rami. There is small question of small Lateral Cortical step-off with the lateral aspect of the Right Femoral Neck and sublet nondisplaced fracture is not excluded. Recommendation is for Computerized Tomography (CT) of the Right Hip for further characterization."

R3's Magnetic Resonance Imaging (MRI) of Pelvis without contrast, dated 1/4/24, documents, "Impression: Nondisplaced, mildly impacted subcapital fracture of the Right Femur with mild surrounding marrow edema. Partial-thickness tearing at the origin of the bilateral Hamstring tendons."

R3's Nurse Progress Note, dated 1/1/24 at 2:20 AM, documents, "Notified by (V38) Certified Nurse Aide (CNA) after returning from supply room downstairs that (R3) was sitting on her bottom in her room in restroom. (R3) stated she had to go to the restroom and could not wait. Call light was on. (V38) was in another resident's room during time of incident. (R3) stated she could not remember how she ended up on the floor. No new injuries noted. Vital signs stable. (R3) transferred safely back into bed. (R3) stated her pain medication was not controlling her pain and expressed she did not want me to leave her side. I explained to (R3) that I could not give her

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anymore pain medication due to her orders but would give it as soon as her orders allowed. (R3) expressed she wanted to go to the emergency room to get looked at because she was now feeling increased pain in her Right Shoulder and groin area with movement. 911 notified to transport (R3) to emergency room."

On 1/16/24 at 8:05 AM, R3 stated R3 fell on the early morning of 1/1/24. R3 stated, "I had to use the bathroom. They (staff) have told me I will get septic if I let urine or bowel movement get into my wound on my bottom. I had to go really bad. I put on my call light and waited 35 minutes. I know I am blind, but I know it was 35 minutes because I keep the television on to help me keep track of time. An entire sitcom show played while I was waiting for someone to help me to the bathroom. Finally, because they (staff) just kept telling me I would get an infection in my wound, I just got up with the wheelchair and made it to the bathroom. That was no small feat. I used the bathroom and tried to lock my brakes on my wheelchair, but apparently I didn't get my brakes locked. I ended up on the floor of the bathroom. My call light was still sounding. It took another 15-20 minutes before anyone came to answer my call light. Then (V38) Certified Nurse Aide (CNA) came in and saw me on the floor. (V38) told me she would be back. So, (V38) CNA and (V24) Licensed Practical Nurse (LPN) came back in around 15 minutes later. They (V24, V38) helped me get back into my wheelchair. (V24) did not do any kind of assessment to see if I was hurt. (V24) asked me if I was having pain and I told her 'I always have pain'. After I got in bed, (V24) told me I 'should be ok' and would get me pain medication when it was due. I told (V24) right then that I think I needed to be sent to the emergency room. So, (V24) complied."

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S9999	Continued From page 40 On 1/16/24 at 11:15 AM, V24, Licensed Practical Nurse (LPN), stated V24 was the nurse for R3 on the night/early morning of 1/1/24 when R3 fell. V24 stated, "We (facility) have been short staffed a lot lately. The residents have had to wait longer on call lights than what they should have to. We (staff) just do the best we can." V24 also stated, "We (staff) have to prioritize who needs the help the most. I am sure (R3) had to wait if she said she did. (R3) is absolutely alert and oriented. I had been in (R3's) room a couple times earlier in the night helping her to the bathroom. I think (R3) was being checked for a Urinary Tract Infection (UTI) the day before she fell." On 1/11/24 at 10:00 AM, V2 Director of Nurses (DON), stated R3 fell on 1/1/24 at 2:20 AM while taking herself to the bathroom. V2 stated, "(R3) told me that she had already been to the bathroom and was transferring herself back to the wheelchair when she fell". V2 stated R3 was sent to the emergency room and was admitted to the hospital. V2 stated R3 was in hospital for several days due to a hip fracture from the fall. V2, DON, stated R3's call light was on at the time of her fall. V2 stated R3's X-Ray was not clear whether she had a fracture or not. V2 stated the "hospital records did show that it could not determine if the fracture was caused by the fall or by other disease process. So the question is did (R3) fall and obtain the fracture or did the fracture cause her to fall. The hospital record said it was undetermined. Either way (R3) should not have been up by herself. The staff should have answered (R3's) call light more timely so that (R3) did not get up independently." The facility call light tracking record for R3's room and bathroom, dated 12/31/23 at 11:00 PM	S9999		

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through 1/1/24 at 11:59 PM, documents R3's call light was activated at 12:04 AM for a total of 12 minutes, and again at 2:51 AM for a total of 13 minutes. This same report does not document R3's call light being activated at time of fall (2:20 AM) on 1/1/24. This same report also documents R3's call light was activated at 2:59 AM for five minutes, 3:39 AM for two minutes, 4:03 AM for two minutes, and 4:16 AM for 16 seconds. On 1/18/24 at 12:45 PM, V43, Maintenance Director, stated the facility has a computerized program to track call lights. V43 stated by the report, you can see what time the call light was activated, de-activated, what room/bed the call light was used for, etc. V43 stated R3's call light report does not show when R3's call light was activated. V43 stated sometimes the system misses activations and he will look into that. V43 stated unsure why R3's call light report documents R3's call light was activated after R3 was sent to the hospital (2:51 AM, 2:59 AM, 3:39 AM, 4:03 am and 4:16 am). V43 stated, "I will have to assess my systems to see what happened. I don't really know."

2. R7's undated diagnoses list documents R7's diagnoses include Parkinson's Disease and Dementia. R7's Minimum Data Set (MDS), dated 12/1/23, documents R7 has severe cognitive impairment, requires substantial/maximal assistance of staff for toileting and dressing, requires supervision/touching assistance for sit to standing movement, transfers, and walking, and R7 is frequently incontinent of urine.

R7's Care Plan, dated as 1/9/24, documents R7 is at risk for acute pain related to recent surgical three screw fixation of left femoral neck fracture. R7's Care Plan, revised 1/10/24, documents R7 is at risk for falls and includes, but is not limited

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S9999	Continued From page 42 to, the following interventions: -1/4/24 R7's name will be placed on the "get up list" to be out of bed prior to shift change. -1/4/24. Offer to assist R7 to the bathroom while conducting rounds during the night. -1/3/24 R7 returned from the hospital and therapy will work with R7 on strengthening and gait. R7 is to have increased supervision and attempt to keep R7 visually in the common areas. -11/30/23 R7 fell while not using R7's walker. R7 did not sleep well the night before which affected R7's safety awareness. Monitor R7's sleeping habits at night and continue frequent checks. -11/11/23 Remind R7 to sit back and upright in the chair, or encourage R7 to lie down if R7 appears tired. -11/10/23 physical and occupational therapy to evaluate and treat. Continue to remind R7 to use walker when ambulating. -9/3/23 Attempted to ambulate without walker. Encourage R7 to use walker when ambulating. R7's fall investigation, dated 11/17/23 at 7:00 AM, documents R7 had an unwitnessed fall, and R7 slipped out of the chair in the lounge. R7's Fall IDT (Interdisciplinary Team) Note, dated 11/07/2023 at 11:53 AM, documents the root cause of the fall as R7 has diagnoses of Parkinson's Disease and Dementia, has severe cognitive impairment, has a lack of safety awareness, often ambulates without assistance, and R7 slipped out of the chair. The post fall intervention is documented as "Resident (R7) is in the safest environment possible, continue current interventions." R7's fall investigation, dated 11/10/23 at 9:10 AM, documents R7 had a witnessed fall while attempting to independently ambulate without	S9999		

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S9999	Continued From page 43 R7's walker. R7's Fall IDT Note, dated 11/10/23 at 11:33 AM, documents the root cause as R7's poor safety awareness, attempt to ambulate without assistance and R7's legs were weak and gave out. The new intervention is for physical and occupational therapy to evaluate and to continue to remind R7 to use R7's walker. R7's fall investigation, dated 11/11/23 at 7:00 AM, documents R7 had a witnessed fall when R7 fell forward out of R7's chair. R7's Fall IDT Note, dated 11/13/23 at 11:28 AM, documents root cause as R7 has Dementia and Parkinson's Disease and frequently rests in the alcove when tired. The interventions already in place in included reminders to use the walker and recommending frequent rest periods. The new intervention was to remind R7 to sit back and upright when in a chair, and encourage to lie down when R7 looks tired. R7's fall investigation, dated 11/30/23 at 11:10 AM, documents R7 was walking out of R7's room and housekeeping and room mate report R7 had fallen. This report documents the room mate did not see the fall, but heard the "crash". R7 reported falling and self transferring after the fall. R7's Fall IDT Note, dated 11/30/23 at 11:30 AM, R7's room mate witnessed R7 fall in R7's room, R7 was not using R7's walker, R7 lost balance and fell. R7 had self transferred post fall and was observed again without R7's walker. The root cause of the fall is R7's diagnosis of Parkinson's disease, severe cognitive impairment, lack of safety awareness, and R7 forgets to use R7's walker. R7 did not sleep well the night prior and	S9999		

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seemed restless prior to the fall. New intervention is documented as monitor R7's sleep habits, encourage to lie down at night and continue frequent checks.

There are no documented staff interviews for the investigations of falls on 11/7/23, 11/10/23, 11/11/23, and 11/30/23, and there is no documentation when R7 was last observed prior to the falls, R7's activity at that time, or when R7 was last toileted or provided incontinence cares.

R7's Nursing Note, dated 1/1/2024 at 3:34 PM, documents R7 was more confused than usual and not easily redirected, R7 seems more unbalanced and was repeatedly not using R7's walker. This note documents the physician was contacted and orders received for urinalysis and to start antibiotic on 1/2/24. There is no documentation that an increase in supervision or frequency of monitoring R7 was implemented after this note.

R7's Nursing Note, dated 1/2/2024 at 11:00 PM, documents R7 stated R7 fell in R7's room earlier this evening and there was no witnesses to this. R7 complained of left groin discomfort and left hip pain.

R7's Nursing Note, dated 1/2/2024 at 11:15 PM, documents R7's family spoke to R7 on the phone and R7 requested to go to the emergency room for evaluation.

The facility's Report to IDPH (Illinois Department of Public Health) Regional Office, dated 1/10/24, documents R7 stated R7 was self transferring to the chair when R7 fell, R7 was able to get off of the floor and into the recliner after falling. This report documents R7 returned from the hospital

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S9999	Continued From page 45 on 1/2/24 with no new orders, and on the morning of 1/4/24, the hospital contacted the facility to report that after further review of R7's imaging, R7 has a fracture and requested R7 return to the hospital. This report documents R7 has a history of repeated falls, shuffled gait, and likes to ambulate independently. This report documents R7 to have increased supervision and attempt to keep R7 visually in common areas. The fall investigation, dated 1/2/24 at 11:00 PM, includes interviews with V9 Licensed Practical Nurse (LPN) and V41 Certified Nursing Assistant (CNA), but does not document when R7 was last observed/check on, R7's activity at that time, and when R7 was last toileted or provided incontinence cares. V41's witness statement dated 1/3/24 documents V41 was completing rounds and heard R7's room mate calling for help. This note documents the room mate reported hearing R7 fall, but did not witness it since the curtain was pulled. V41 asked R7 if R7 fell, and R7 reported "yes". R7 was asked how R7 got into the recliner, and R7 stated R7 stood on R7's own to transfer into the recliner. R7's Hip and Pelvis X-ray dated 1/3/24 at 12:51 AM documents "History: Per ordering provider: Unwitnessed fall, left hip pain." "Acute impacted subcaptial femoral neck fracture on the left (let hip fracture)." R7's Response History Report, dated 12/19/23-1/17/24, documents to check R7's location every hour and the last completed check on 1/2/24 was at 2:22 PM. R7's fall investigation, dated 1/4/24 at 3:25 AM, documents V50, CNA, witnessed R7 standing near R7's dresser, removing R7's wet incontinence brief, and R7 fell to the floor onto	S9999		

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S9999	Continued From page 46 R7's left side. R7's fall investigation, dated 1/4/24 at 7:00 AM, documents R7 had an unwitnessed fall and was found asleep on the floor mat beside R7's bed. There is no documentation when R7 was last checked on or assisted with toileting/incontinence cares prior to these falls. On 1/17/24 at 12:23 PM, V9, LPN, stated that night (1/2/24), R7 had been walking without R7's walker, which is usual for R7. V9 stated V9 did not think R7 had 15 minute checks in place that night, but that is an intervention that can be used if the resident is confused. V9 stated 15 minute checks are documented on a paper flowsheet. V9 stated "we just watched him (R7) closely that night." V9 stated R7's fall was not witnessed, R7 told R7's family that R7 fell, so V9 went to check on R7. V9 stated R7 reported that R7 self transferred off of the floor as R7 was physically able to do that. V9 stated prior to the fall R7 was in R7's room in R7's recliner, but did not recall when R7 was last observed prior to the fall. V9 stated the nurses document information such as when last checked on and last toileted on a form. On 1/17/24 at 12:43 PM, V2, Director of Nursing (DON), stated the facility is in the process of transitioning from paper fall investigations to computerized forms. V2 stated, "What you have for R7's falls, is the entire investigation." V2 confirmed there is no documentation to identify the last time R7 was checked on and R7's activity at that time, or when R7 was last toileted/provided incontinence cares prior to the falls. V2 stated staff should keep frequent eyes on R7 when R7 is up and about and obtain R7's walker. V2 stated 15 minute checks are implemented post fall and at the nurse's discretion if the resident is more	S9999		

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(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
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confused or has gait changes. V6, Assistant DON, stated 15 minute checks are documented in the task section of the resident's electronic medical record. At 1:05 PM, V2 stated therapy and increased supervision were the post fall interventions for R7's fall on 1/2/24. V2 stated the root cause and post fall interventions are documented in the IDT notes. V2 confirmed the 1/4/24 post fall intervention is to offer toileting during the night while conducting rounds. At 1:11 PM, V6, ADON, stated R7 is incontinent and also uses the toilet, R7's room mate is checked and changed every two hours during the night, and staff should be checking and offering toileting to R7 when checking R7's room mate during the night. V6 stated staff should also be offering R7 toileting routinely during the day as well.

On 1/17/24 at 4:16 PM, V30, Nurse Practitioner, stated usually when there are changes in a resident's condition such as increased confusion, the nursing staff will increase supervision and monitoring. V30 stated if frequent checks or increased monitoring were implemented for R7 it would have lowered R7's risk for falling.

3.) R21's Minimum Data Set, dated 12/11/23, documents R21 has severe cognitive impairment, is dependent on staff when moving from sitting to standing position, requires substantial/maximal assistance of staff for toileting, and is frequently incontinent of bowel and bladder. The only documented Fall Risk Assessment in R21's electronic medical record is dated 12/11/23.

R21's Nursing Note, dated 12/11/2023 at 2:08 AM, documents R21 was found lying on the floor beside R21's bed with R21's head against the night stand. R21 was unsure how R21 fell out of bed and reported pain to the back of R21's head.

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	IL6004261	A. BUILDING: _____ B. WING _____	C 01/23/2024

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This note documents R21 had a red area to the left forehead and denied pain to the area.

R21's Post Fall Investigation, dated 12/11/23, documents R21 had an unwitnessed fall at 1:45 AM. R21 was found on the floor of R21's room with R21's head positioned near the night stand. This investigation documents conflicting information, recorded by V51, CNA, that R21 was sleeping prior to the fall when last checked at 12:00 AM, R21 was toileted at 12:00 AM, and R21 was repositioned last at 11:00 PM bed check. R21's undated Fall/Incident Investigation Documentation documents R21 was found on the floor at 1:45 AM on 12/11/23, and was last observed by the CNA sleeping at 12:00 AM. R21's current interventions include low bed, nonskid footwear, call light within reach, and staff to supervise toileting. Fall mats were placed beside the bed as the new intervention. The root cause is identified as R21 has diagnoses of Dementia, polyneuropathy, and insomnia, has severe cognitive impairment, and R21 was unable to state the cause of the fall.

Attempts were made to contact V51, but were unsuccessful.

On 1/16/24 at 10:21 AM, V2, DON, stated fall risk assessments are completed upon admission, quarterly, and post fall, and V2 confirmed these assessments are documented in the assessment section of the resident's electronic medical record. V2 stated V2 completes the typed summary of the fall investigation, and the nurses and CNAs fill out the other fall forms. V2 reviewed R21's fall investigation and confirmed documented information is conflicted as to when R21 was last toileted/changed prior to the fall. V2 stated R21 either attempted to get up or rolled

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from the bed, and R21 wasn't able to say what the cause was. V6, ADON, stated R21 was incontinent and also required toileting assistance, during the night R21 should have been on a check and change program. V2, DON, stated the expectation is for staff to check for incontinence/change R21 at least every two hours. At 10:55 AM, V2 provided R7's Fall Risk Assessment, dated 12/21/22, and V2 stated that was the last assessment V2 could locate prior to 12/11/23. At 11:04 AM, V2 confirmed R21's entire fall investigation was provided.

The facility's Fall Policy and Procedure, revised 12/6/23, documents fall risk assessments are completed upon admission, quarterly and with changes in condition, and interventions are based on the identification of high fall risk. This policy documents to assess for injury, initiate neurological protocol, assess root cause, and initiate a timeline of events. This policy documents nursing staff are responsible for ensuring safety precautions are consistently implemented and maintained.

4.) R21's Minimum Data Set ,dated 12/11/23, documents R21 has severe cognitive impairment. R21's Nursing Note, dated 12/11/2023 at 2:08 AM, documents R21 was found lying on the floor beside R21's bed with R21's head against the night stand. R21 was unsure how R21 fell out of bed and reported pain to the back of R21's head. This note documents R21 had a red area to the left forehead and denied pain to the area. This note documents neurological assessments were initiated and the Nurse Practitioner was notified by fax (electronic facsimile). There are no documented post fall assessments in R21's medical record after 12/12/23 at 6:57 PM. The last documented post fall neurological

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assessment in R21's medical record is dated 12/11/23 at 4:30 PM.

On 1/16/24 at 10:21 AM, V2, Director of Nursing, stated post fall assessments are documented as part of the neurological assessments or in a progress note, and the facility has both paper and electronic forms. V2 stated the neurological assessments have time frames that start every 15 minutes four times, then every 30 minutes four times, then hourly four times, then every four hours. V2 confirmed post fall assessments continue for 72 hours after the fall. V2 stated the nurses notify the resident's power of attorney, physician and nurse manager on call. V2 stated if there is no injury from the fall, then the physician/provider can be notified by sending an electronic facsimile. V2 stated if there is an injury, then V2 would expect the staff to call the provider. V2 stated V2 would not consider complaints of head pain and reddened forehead post fall as an injury, and the facility's policy is to "monitor" if the resident does not take an anticoagulant. At 10:55 AM, V2 stated V2 was unable to locate any additional post fall and neurological assessments.

On 1/17/24 at 12:20 PM, V30, Nurse Practitioner (NP), stated the provider should be notified with every resident fall. V30 stated there are notifications that can be made by fax for an uncomplicated witnessed fall with no injuries and no need for clinical support or emergency medicine, and other notifications should require a telephone call to the provider. V30 stated when a resident has an unwitnessed fall, a complete neurological exam should be completed and the provider should be called, not faxed, regardless of whether or not they are on an anti-coagulant. V30 stated, "There are neurological processes

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that may be affected that may only show up with further diagnostic testing such as a Computerized Tomography (CT) exam. The facility can not always tell if there is an internal bleed or some other internal injury and would need to notify the physician by phone to receive prompt instructions for further care of the resident. In those cases, a fax is not an acceptable form of notification."

The facility's Physician-Family Notification-Change in Condition policy, revised 11/13/18, documents the facility will consult with the resident's physician or Nurse Practitioner when there is an accident involving the resident that results in injury and has the potential for requiring physician intervention.

The facility's undated Neurological Assessment policy documents: "Unless otherwise ordered by the physician, neuro (neurological) checks will be completed along the following schedule: Q (every) 15 minutes times 1 hour, Q 30 minutes x 2 hours, Q 4 hours x 24 hours and then Q shift X 48 hours." "Notify physician immediately regarding any changes in the neurological assessment or other signs of possible increased intracranial pressure i.e.(for example), headache, change in mentation, vomiting or irregular breathing."

(A)