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
	IL6016935	A. BUILDING: _____ B. WING _____	C 02/16/2024

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BELMONT VILLAGE LINCOLN PARK	700 WEST FULLERTON AVENUE CHICAGO, IL 60614

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S 000	Initial Comments Invesitgation of Facility Reported Incidents of: 10-06-2023/IL166091-State citation cited: Section 330.710 Resident Care Policies. 11-12-2023/IL166805-State citation cited: Section 330.4240 Abuse and Neglect. 11-01-2023/IL166814-State citation cited: Section 330.710 Resident Care Policies. 11-05-2023/IL166816-State citation cited: Section 330.710 Resident Care Policies. Complaint Investigation: 2480497/IL168891-State citation cited: Section 330.710 Resident Care Policies.	S 000		
S9999	Final Observations Statement of Licensure Violations 1of 2: 330.710a) 330.710c)3) A)B)C)D)E)F)G) 300.710d)1)2) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. c) The written policies shall include, but are not limited to, the following provisions: 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated	S9999		

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S9999	Continued From page 1 with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: A) Analysis of the risk of injury to residents and nurses and other health care workers, taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs. B) Education of nurses in the identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling. C) Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment. D) Restriction, to the extent feasible with existing equipment and aids, of manual resident handling or movement of all or most of a resident's weight, except for emergency, life-threatening, or otherwise exceptional circumstances. E) Procedures for a nurse to refuse to perform or be involved in resident handling or movement that the nurse, in good faith, believes will expose a resident or nurse or other health care worker to an unacceptable risk of injury. F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident.	S9999		

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S9999	Continued From page 2 G) Consideration of the feasibility of incorporating resident handling equipment or the physical space and construction design needed to incorporate that equipment when developing architectural plans for construction or remodeling of a facility or unit of a facility in which resident handling and movement occurs. (Section 3-206.05 of the Act) d) For the purposes of subsection (c)(3): 1) "Health care worker" means an individual providing direct resident care services who may be required to lift, transfer, reposition, or move a resident. 2) "Nurse" means an advanced practice nurse, a registered nurse, or a licensed practical nurse licensed under the Nurse Practice Act. (Section 3-206.05 of the Act) These requirements were NOT met as evidenced by: Based on interviews and record reviews the facility failed to follow their policy and procedures for fall reduction by a.) not reassessing fall risks as needed and b.) not ensuring that the residents' care plan interventions were changed/updated with each fall. These failures affect three (R3, R5, R7) out of three residents reviewed for falls with injuries. These failures resulted in R3, R5, and R7 experiencing repeated falls at the facility, which resulted in R3 sustaining a head injury and requiring staples to R3's head, R5 sustaining a head injury, and R7 sustaining a head injury. Findings include: R7 is an 82-year-old female with diagnoses	S9999		

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S9999	Continued From page 3 history of Dementia, Diabetes (w/o/without Insulin), Gastro-esophageal reflux disease, Bilateral hearing loss, who was admitted to the facility on 08/01/2022. R7's PAL (Personal Assistance Liaison) Approach Chart/Service Plans dated September 2023 through February 2024 documents in part R7 uses a wheelchair as a mobility aid, is continent and to be taken to the bathroom every 3-4 hours while awake and assist as needed, requires wheelchair escort service to meals and activities, she is a fall risk with interventions including clear clutter and trip hazards, ensure resident is wearing appropriate non-slip footwear, safety room checks with increased frequency due to fall risk, put hospital in low position while in bed, provide multiple daily reminders, safety room checks with increased frequency due to fall risk. No changes noted to R7's care plan from September 2023 through February 2024. Reviewed facility's list of R7's fall incidents and notes 10/28/23 fall, 12/29/23 fall, 01/17/24 fall, 10/08/23 fall, and 11/01/23 fall. R7's progress note dated 10/06/2023 at 8:54pm documents R7 was in room with PAL (Personal Assistance Liaison) getting ready for bed and slid out of chair. Physician Communication Report dated 10/07/2023 documents R7 in room with PAL getting ready for bed, and resident slid out of chair. Resident was agitated at the time. Witness states resident did not hit head, just landed on buttocks. No Fall Review Form noted for R7's 10/06/2023 fall.	S9999		

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S9999	Continued From page 4 R7's progress note dated 10/08/2023 at 2:00pm documents R7 in room with PAL and experienced fall while "transferring from toilet to chair". Physician Communication Report dated 10/08/2023 documents R7 had fall while transferring from toilet to chair. Staff present at the time of fall. Fall Review Form dated 10/08/2023 documents R7 had a witnessed fall while transferring from toilet to wheelchair. R7's progress note dated 10/28/2023 at 12:30pm documents that R7 noted on the floor in common area with wheelchair at side and right arm extended while lying on right side. Physician Communication Report dated 10/28/23 documents R7 had an unwitnessed fall out of wheelchair in common area. Observed lying on right side with right arm outstretched. Fall Review Form dated 10/28/2023 documents R7 had an unwitnessed fall. R7's progress note dated 11/01/2023 at 3:00 PM documents that R7 was very lethargic after medications. R7 was falling asleep in her wheelchair slowly leaning forward. R7 leaned too much, and her left forehead hit the wall and R7 fell to the floor. Sent out 911 but returned later in the day. Fall Review form dated 11/01/2023 documents R7 had an unwitnessed fall, resident was sitting in wheelchair very lethargic. R7 was falling asleep and leaning forward. R7 leaned too much, and her head hit the wall and fell out of chair.	S9999		

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S9999	Continued From page 5 R7's progress note dated 12/30/2023 at 10:00 PM documents that R7 alert with periods of confusion. R7 slide to floor from bed. No Fall Review Form noted for R7's 12/30/2023 fall. R7's progress note dated 01/05/2024 at 5:15 PM documents that R7 had an unwitnessed fall in her bedroom. Resident was sitting in the side of her bed and slid to the floor. No Fall Review Form noted for R7's 01/05/2024 fall. R7's progress note dated 01/06/2024 at 3:00 AM documents that R7 was found sitting on floor next to bed. Staff assessed patient, range of motion within normal limits. PALs and nursing staff assisted patient off the floor with no problems to report. No Fall Review Form noted for R7's 01/06/2024 fall. R7's progress note dated 01/07/2024 at 2:00 PM documents that R7 continues to refuse to stay in bed. Redirected several times poor results. R7 slid to floor while PAL was trying to provide peri care. No injuries noted at this time remains in bed for Covid, no shortness of breath or respiratory distress noted at this time. R7's progress note dated 01/07/2024 at 9:15 PM documents that R7 was on the floor. Upon review of video, R7 slowly lowered herself onto floor mat on buttocks. R7's husband and R7's provider group notified.	S9999		

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S9999	Continued From page 6 Physician Communication Report dated 01/07/24 documents R7 slowly lowered herself onto floor mat on buttocks on floor mat while reaching towards wheelchair, trying to get out of bed. No Fall Review Form noted for R7's 01/07/2024 fall. R7's progress note dated 01/10/2024 at 6:37 PM documents that R7 observed sitting on buttocks in room on floor 01/09/2024. Writer (nursing staff) informed by PAL that resident did not fall, she (PAL) assisted resident to the floor to avoid falling. No Fall Review Form noted for R7's 01/10/2024 fall. R7's progress note dated 01/17/2024 at 10:00 PM documents that R7 lowered self to ground in the day room. No injuries noted at that time. At 10:00 PM, when R7 was getting assisted to go to bed, it was discovered that R7 has a purple bruise with a bump on right temple. Writer (nursing staff) called ambulance and R7 was sent to hospital. Fall Review form dated 01/17/2023 documents R7 had a head injury. R7's progress note dated 02/02/2024 at 10: 25 PM documents that R7 had an unwitnessed fall, found by PAL. R7 was on her back with walker in between her lower leg. No Fall Review Form noted for R7's 02/02/2024 fall. R7's progress note dated 02/05/2024 at 7:00 AM documents that R7 found on floor in room sitting on buttocks by PAL.	S9999		

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S9999	Continued From page 7 No Fall Review Form noted for R7's 02/05/2024 fall. R7's Fall Risk Assessment dated 11/9 documents R7's fall risks include being disoriented x/times3, has had one to two falls in the past 12 months, takes one to two psychotropic medications currently and within last 7 days, R7 has one to two predisposing diseases. Facility presented document: "Fall Reduction Preventative" dated 01/18/2023: documents in part, "Purpose: To mitigate resident risk of injury from falls by identifying risk factors and applying individualized interdisciplinary fall management strategies ...Policy: All residents will be assessed for risk of falls just prior to, or at the time of, move-in, and periodically at the discretion of the DRCS (Director of Resident Care) ...A Resident Care Plan with individualized "approach" instructions will be developed by a nurse. Instructions and individualized interventions to help mitigate the risk of injury from falls will be included for those residents at risk. The Care Plan will be updated with fall management interventions, as appropriate ...Responding to a Fall: Complete internal community notification of DRCS (Director of Resident Care Services) and/or ED (Executive Director) ...Conduct an assessment and update the corresponding Resident Care Plan and Approach Chart if indicated, to reflect any additional assessed interventions and/or services ... Fall Review: The nurse responding to the fall will complete the first part of page 1 of the Fall Review form and forward it to the DRCS. The DRCS will complete the rest of page 1 and all of page 2 of the form and update the assessment/plan of are if indicated. If a new assessment is completed, the	S9999		

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PALs (Personal Assistant Liaison) will be informed of the new interventions then the approach charting will be printed and placed on the floor for PAL documentation ...Documentation Post Fall: The Fall Review form should be filed in a Fall Investigation Notebook. Preparation and filing of the incident report to be done per state regulations."

On 02/14/24 at 2:30 PM, V7 (Memory Program Coordinator) stated that a lot of R7's behaviors are triggered by care like showering, changing. V7 said that R7 can swing sometimes at the staff and can be verbally aggressive with her language. V7 said that R7 kicks staff sometimes but not to other residents. V7 said that she oversees the caregivers who work on the second and third floor. V7 said that she oversees day-to-day programming operations for the memory care unit. V7 said that she collaborates with V2 (Director of Resident Care Services/DRCS). V7 said that if there is any resident fall, there is a conversation that V7 and V2 must discuss interventions to put in place, along with V1 (Executive Director). V7 said that some interventions may include a room setup could be changed, floor mats, hospital bed, and more. V7 stated that R7's recent falls have happened in the day room. V7 said that R7 is still appropriate for this setting. V7 stated that R7 has had maybe four to five falls within the past six months. V7 said that she remembered being told about R7's fall in November 2023 but V7 does not have details on it.

On 02/15/24 at 11:44 AM V21 (Personal Assistant Liaison/PAL) said that she sometimes does not need help with caring for R7. V21 said that other staff have said that R7 is hard to deal with. V21 said that sometimes if R7 is too sleepy and

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doesn't cooperate, then she will ask for assistance. V21 said that one time during her evening working shift, R7 was in her room due to being on isolation and slid out of bed. V21 said that she cannot remember when it happened. V21 said that R7 is incontinent and requires assistance in changing her briefs and toileting.

On 02/15/24 at 2:19 PM V28 (Family Nurse Practitioner) stated that the facility has notified V28 regarding R7's falls. V28 stated that he does not recall the exact number of R7's falls that have been reported to V28. V28 said that R7 is a dementia patient in the memory care unit. V28 said that R7 was previously ambulating and within the past six months, R7 was sent to the behavioral hospitals and upon returning R7 is mostly using wheelchair due to her declining in her abilities. V28 stated that possibly due to R7 being in the wheelchair may have contributed to her falls due to not being accustomed to a wheelchair. V28 said that other interventions to reduce her falls include lab work done to rule out any other problems, PT (Physical Therapy) OT (Occupational Therapy) treat, Seroquel medication was reduced.

On 2/15/24 at 3:57 PM, V2 (Director of Resident Care Services/DRCS) stated that nurses and Personal Assistant Liaisons/PALs should be following the individualized care plan based on residents' condition. V2 stated that he is the fall prevention coordinator since November 2023. V2 said that he is responsible for making/updating the residents' PAL (Personal Assistance Liaison) Approach Chart/Service Plans. V2 stated that a lot of the falls that have occurred are self-lowering. V2 said which means that the residents went from standing to picking something up from the ground. V2 said that in

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general if there was an unwitnessed fall, the facility would have to review the video monitoring system and determine if it was a fall. V2 stated that after a fall occurs the nurses are supposed to assess the resident, provide first aid, call 911 if needed, and notify the provider. V2 stated that after a fall, a Fall Review and incident report forms are completed which are internal documents. V2 said that the fall is recorded in the residents' progress notes. V2 stated the fall risk assessment provides a score and a score of ten is the highest score possible. V2 said that a score of ten means a high fall risk. V2 said that a high fall risk resident, interventions may include a floor alarm (would alert nursing staff when a resident puts their feet on the mat), floor mat doesn't have an alarm just helps prevent an injury if resident were to fall on it. V2 stated that these interventions mentioned would be documented in the approach chart under clearing clutter and trip hazards. V2 stated that fall risk residents' care plan should be based off the fall policy. V2 stated that for example, if a resident has had multiple falls, some of the interventions that staff will add are a high low bed (a bed that goes all the way down, almost ground level) intervention to the resident's care plan. V2 stated that the residents' care plans are based around the PALs. V2 said what the PALs can observe and monitor. V2 stated that R7's care plan could have been updated but just doesn't reflect on R7's care plan. V2 stated that sometimes if the resident's care plan is updated, it would be added by handwritten. V2 stated that transition meetings are held weekly to determine residents that are not fit to continue residing in the facility. V2 stated that there are no residents in the facility that are not appropriate to reside in the facility. V2 stated that the staff had a transition meeting last week and R7 was discussed because of R7's falls. V2

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S9999	Continued From page 11 stated that he has not reached out to R7's provider regarding R7's falls. R3 is an 84-year-old female with diagnoses not limited to Dementia, Osteoporosis, and seizure disorders who was admitted to the facility 05/29/2021. On 02/13/2024 at 9:57AM, R3 observed fully dressed sitting in a wheelchair located on the first floor of the facility in the lobby. R3 states she fell at the facility but does not know what happened when she fell. R3 states she ambulates via a wheelchair and is able to toilet herself. On 02/14/2024 at 2:47PM, V7 (Memory Program Coordinator) states R3's 9/30 score on the Montreal Cognitive Assessment/MOCA indicates that R3 is a lower functioning resident who requires memory care. V7 states R3 has a high sense of awareness but has safety awareness issues related to R3's gait. V7 states R3 can navigate the facility and make her own decisions. V7 states R3 ambulates via wheelchair and requires assistance with dressing and transferring. V7 states R3 uses incontinent briefs but is aware when R3's needs to use the restroom to toilet herself. V7 states R3 wears incontinent briefs in case of an accidental incontinence episode. V7 states R3's functional abilities and limitations are verbally communicated with the nursing staff. V7 states R3 resides on the 6th floor of the facility and this floor is designated for assisted living. V7 states there is not an assigned nurse on the 6th floor of the facility. V7 states a nurse is assigned to the 5th floor and residents who reside on the 6th floor knows to go to the 5th floor to receive their medications from the nurse assigned to the 5th floor. V7 states residents are allowed to consume	S9999		

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alcohol inside the facility. V7 states alcohol is provided to the residents by the facility on Thursdays and Mondays during parties and happy hour. V7 states usually there is a 2-drink minimum for residents when alcohol is served. V7 states some residents have alcohol restrictions, so the facility restricts or limits their access to alcohol. V7 states residents who are more high functioning can have alcohol inside of their rooms at their leisure. V7 states during parties on Thursdays, the facility provides cheese and wine to the residents and multiple PALs (Patient Assistant Liaisons) are onsite monitoring the residents during alcohol consumption. V7 states the facility's happy hour is a program led by activities department and held on Mondays. V7 states she is not sure if any residents in the facility have injured or harmed themselves due to alcohol consumption.

On 02/14/2024 at 8:34PM, a telephone interview was conducted with V17 (Licensed Practical Nurse/LPN). V17 states he has been working at the facility for one year now and is currently working at the facility tonight and is assigned to care for residents on the 5th, 6th, and 7th floors of the facility. V17 states he administers medication on the 5th floor of the facility. V17 states only one resident who resides on the 6th floor of the facility pays extra to have their medications delivered to them. V17 states all other residents are expected to come down to the 5th floor to receive their medications. V17 states if there are any residents who do not come down to receive their medications, he gets assistance from the PALs/Patient Assistant Liaisons to help bring the residents to the 5th floor. V17 states he was not the nurse caring for R3 the day R3 sustained a fall and was bleeding from her head. V17 states he does not have any memories of

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BELMONT VILLAGE LINCOLN PARK	700 WEST FULLERTON AVENUE CHICAGO, IL 60614

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that fall. V17 states R3 has a floor mat inside of her room that notifies staff when R3 gets in and out of bed. V17 states this prompts staff to go and check in on R3 if the notification system alarms. V17 states staff is made aware through a phone that beeps and makes noise whenever R3 gets out of bed. V17 states R3's floor mat is always in place rather R3 is inside of her room or not. V17 states he can't recall any specific incidents when R3 has fallen at the facility. V17 states R3 usually goes to bed around 8-9pm, but R3 does have family who visits R3 in the evening and sometimes R3 will stay up later and talk with family. V17 states alcohol is served to residents at the facility and V17 states he witnessed R3 intoxicated on 02/11/2024. V17 states R3 was provided two beers by the activities department. V17 states he observed R3 with two beer cans, one was an empty can of beer and R3 was drinking the other can of beer. V17 states when R3 was intoxicated on 02/11/2024, V17 observed that R3 had issues with her fine motor skills and R3 had issues using R3's keys to get in her room. V17 states R3 was not aware of the time and R3's words were slurred. V17 states he has not witnessed any of the resident's harm themselves due to alcohol intoxication.

On 02/15/2024 at 10:20AM, V2 (Director of Resident Care Services) provided surveyor with the telephone numbers for two PALs (Patient Assistant Liaisons/V19 and V20) and one nurse (V16) and states these employees were working on 11/05/2023, the day R3 fell and sustained a head injury. V16's (LPN) telephone number previously provided to surveyor by V1 (Executive Director) on 02/14/2024.

On 02/14/2024 at 4:13PM, an attempt to contact V16 (LPN) was made, call unsuccessful, left

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S9999	Continued From page 14 voice mail, awaiting call back. On 02/15/2024 at 10:22AM, V20 (PAL) states she was not assigned to care for R3 on 11/05/2023 and has no recollection of R3 having a fall on 11/05/2023. V20 states she has never worked with residents residing in assisted living. On 02/15/2024 at 10:24AM, an attempt to contact V19 (PAL) was made, call unsuccessful, left voice mail, awaiting call back. On 02/15/2024 at 3:57 PM, V2 (Director of Resident Care Services/DRCS) states he is the facility's fall coordinator and has been working at the facility since October 2023. V2 states PALs (Patient Assistant Liaisons) are responsible for monitoring for any resident change in condition or behaviors and PALs should be paying close attention to the residents. V2 states he has been the facility's Fall Coordinator since late November 2023. V2 states the resident fall risk assessments are completed initially upon admission. V2 states if residents are found on the floor, then the facility would consider that a fall. V2 states documentation of a fall is documented in the progress notes and fall review form. V2 states a Fall Risk Assessment is to determine the level of risk a resident has in regard to falling. V2 states he is unsure of the score range for the fall risk assessments or what the scores are indicative of but V2 states he knows that the highest fall risk score is a 10. V2 states as the DRCS, it is at his discretion for when to update a residents' care plan after a resident experiences a fall. V2 states the facility has a "Transition meeting" which is held every week on Tuesdays where the facility discusses residents who may not be fit to continue residing in the facility. V2 states there are currently no residents residing in the facility	S9999		

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S9999	Continued From page 15 who are not fit to reside in the facility. R3's MOCA (Montreal Cognitive Assessment) dated 04/04/2023 documents that R3 has a score of 9/30, indicating that R3 is lower functioning and requires memory care. R3's approach chart and service plan reviewed from October 2023 through January 2024 and does not show documentation of updates or changes to R3's fall risk interventions following a fall. R3's progress note dated 11/05/2023 documents R3 fell inside of R3's room and was found on the toilet holding a towel to the back of R3's head with blood noted on R3's head and neck. R3's nursing progress notes reviewed for the past 6 months and documents that R3 fell on the following dates: 10/17/2023 at 8:30PM- R3 fell on buttocks while trying to reach for a chair- No injury. 10/28/2023 at 10PM- R3 observed on the floor by staff, R3 unsure of how she ended up on the floor, no injury. 11/05/2023 12:30AM- R3 fell in room and noted holding a towel to the back of R3's head, R3 noted bleeding from head. R3 sent to ER, returned to facility with 4 staples to back of head. 12/23/23 at 8:15PM- R3 observed on the floor and R3 states she slipped, no injury. 01/9/24 at 10:15PM- R3 fell at 8PM, R3 observed on the floor in R3's doorway in front of her wheelchair, no injuries. R3's nursing progress note dated 2/11/24 documents that R3 was observed consuming alcohol and noted intoxicated with slurred speech and poor body control.	S9999		

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Facility document listing R3's fall history for the past 6 months reviewed and documents that R3 fell at the facility on the following dates: 10/17/2023, 10/28/2023, 11/05/2023, 12/23/2023, and 01/09/2024.

R3's fall history reviewed for the past 6 months and documents that R3 had a total of five falls within the last four months with one injury resulting in R3 sustaining a head injury with bleeding.

Incident report dated 11/05/2023 documents R3 had an unwitnessed fall in her room. R3 unable to articulate how R3 fell. R3 sent to local ER/emergency room for evaluation and returned to the facility with four staples to R3's head.

R3's Hospital After Visit Summary dated 11/05/2023 documents R3 was diagnosed with blunt head trauma, laceration of scalp with laceration repair with staples.

R3's Fall Risk Assessment was requested from the facility for the past 6 months.

On 02/15/2024 at 12:51PM, V11 (Senior Vice President of Clinical Operations) states to this surveyor that the facility's fall risk assessments are completed initially upon admission and after that it is at the discretion of the DRCS (Director of Resident Care Services.) V11 brings surveyor the facility's fall policy and points to the form to visually show surveyor the verbiage that states the fall risk assessments are completed at the discretion of the DRCS, who is currently V2 (Director of Resident Care Services).

There is no documentation to show that R3 was

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S9999	Continued From page 17 assessed for risk for falls within the last 6 months. R3's Fall Review Form reviewed for the past 6 months and documents that R3 fell at the facility on: 10/17/2023, 10/28/2023, 11/05/2023, 12/23/2023, and 01/09/2024. Facility policy dated 01/18/2023 titled "Fall Reduction Preventative" documents in part, "Purpose: To mitigate resident risk of injury from falls by identifying risk factors and applying individualized interdisciplinary fall management strategies. 2. All residents will be assessed for risk of falls just prior to, or at the time of, move-in, and periodically at the discretion of the DRCS. 3. The care plan will be updated with fall management interventions, as appropriate." On 2/15/24 at 10:19 AM, V10 (Licensed Practical Nurse) stated R7 was sitting in a wheelchair in the activity room. R7 was close to the wall. R7 can move self to the wall. R7 was falling asleep and leaning forward, fell and hit R7's head on the wall. It looked like redness on R7's forehead. The policy is, if there is a fall and the resident hit their head, to immediately send them out to emergency department. R7 came back a few hours later with no new orders. I don't remember if I saw R7 fall or someone else reported to me. Previously, R7 was able to stand on own with one person, now R7 is a two person assist. R7 eats on own. R7 needs assistance with dressing. R7 sometimes tries to get up from the chair and bed on own. PALS (Personal Assistant Liaisons) monitor everybody, all residents. On 2/14/24 at 2:00 PM, V7 (Memory Program Coordinator) stated R7 has been here a couple of years. R7 was originally able to walk with good gait. R7's dementia has progressed. Physical	S9999		

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Therapy decided a wheelchair is better for R7 because R7's gait was unsteady. R7 sometimes propels self in the wheelchair. A lot of R7's behaviors are triggered around care, like showering, changing. R7 can swing at staff, be verbally aggressive, kicks at staff.

I oversee caregivers, programming/enrichment leaders, day-to-day operations on the second and third floors. After every fall there is a conversation to discuss interventions to put in place, room setup, floor alarm, floor mat, hospital bed. R7's recent falls have happened in the day room. R7 falls asleep in the wheelchair. We have R7 sit behind the table. After every fall, the doctor and psychiatrist are notified. I think R7 is appropriate for this setting. I don't know exactly, but R7 has maybe had four-five falls within six months. The day room is monitored with an Enrichment Leader and at least one PAL (Personal Assistant Liaison). There are approximately 15-18 residents in the day room. I think there is enough staff. This is not a setup where we can have one-to-one. I was told about R7's fall on 11/1/23 but I was not on the floor when that happened and have no other details. R7 can assist with some dressing but needs assistance with everything. PALS assist R7 with ADL (activities of daily living) care.

On 2/14/24 at 3:50 PM, V14 (PAL (Personal Assistant Liaison) Trainer) stated I've worked here for two years. I work on the memory care units on the second and third floors. R7 needs assistance with all ADLs (activities of daily living), showering, getting up. R7 is in a wheelchair, not able to walk on own. We have eyes on R7 throughout the day, when out in common areas and receiving ADL care.

On 2/15/24 at 10:34 AM, V24 (PAL (Personal

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Assistant Liaison)) stated I started here 10/31/23. I work on the third floor often and I am familiar with R7. R7 needs help getting out of bed, getting dressed, showering, grooming, daily tasks, sometimes getting in out of the wheelchair. R7 is not stable and when R7 tries to stand, R7 just falls back into the wheelchair. I don't recall R7's fall on 11/1/23.

On 2/15/24 at 11:27 AM, V21 (PAL (Personal Assistant Liaison)) stated I've been working here for six months. I normally work on the third floor. I am familiar with R7. R7 is a fall risk. R7 knows how to walk but with assistance. We have R7 on the sit-to-stand. R7 has not used the walker in a while. Now R7 uses the wheelchair and sit-to-stand. R7 needs two people to assist with everything, transfer wheelchair and bed. R7 needs help with ADL (activities of daily living) care. There should be two people always assisting R7. The approach charting is individual for each resident and on our assignment. R7 probably fell two to three times since I've been working here. I worked 11/1/23 on the third floor, 2:30pm-10:45pm. I don't remember seeing R7 fall. I heard about it because R7 was sent out and said R7 hit R7's head on the table. There should be an Enrichment Leader and at least one PAL assigned to the common area when residents are in there. R7 doesn't fall frequently except when R7 tries to get up on own.

On 2/15/24 at 1:20 PM, V27 (Enrichment Leader) stated I lead activities throughout the day, word games, sing-a-longs, history, daily chronicles, current and old events, yoga, something to occupy their time and minds. We talk about personal memories. I work floors 2, 3, and 4. Floors 2 and 3 and 4 are dementia but 4th floor is less progressed dementia. I've worked here one

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year, morning shifts (9AM-5:30PM) and I am familiar with R7. R7 used to be able to walk on own, now R7 is in a wheelchair. Some days R7 is awake and alert and some days R7 is tired and sleepy. R7 is very sweet and nice. I was working 11/1 on the third floor. I don't recall R7 having a fall. The common area is the day room. The PALS (Personal Assistant Liaisons) are always in the day room keeping an eye on the residents if they are not helping a specific resident somewhere else. While teaching, I'm still looking out for the residents if they need assistance. I'm in the day room from 9:30AM-11:30AM. I let the PALS know if I have to leave the floor. There is an afternoon session of activities from 1:30PM-4:30PM.

On 2/15/24 at 4:00 PM, V2 (Director of Resident Care) stated Nurses and PALS (Personal Assistant Liaisons) should be monitoring residents for change in condition, behavioral or medical. The nurses and PALS should be making sure they are following the individualized care plan based on the resident's condition. Not every resident that looks sleepy or lethargic is going to fall. They (staff) should be paying close attention to the resident that is lethargic and looking sleepy sitting in the wheelchair in the common area. I am the falls coordinator since late November. Fall risk assessments are upon admission and based on initial assessment. Going from one level to the other is self-lowering. We would have to review the video monitoring system to determine if a resident being found on the floor was a fall. Based on fall risk assessment the care plan is adjusted to help prevent falls. After a fall, nurses are supposed to assess the resident, provide first aide, call 911 if needed, utilize video consultation with the doctor to determine need to be sent out. After a fall, a Fall Review form is completed,

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variance/incident report is completed, they are internal documents. Document in progress notes that fall occurred. High fall risk resident interventions may include floor alarm (alerts to when resident puts feet on the floor), floor mat, high-low bed, pendants (emergency response button worn around the neck). Interventions are documented in the approach chart. Updating the care plan is at the discretion of the DRCS (Director of Resident Care Services). Example of when update the care plan is a resident has had multiple falls, and we added high-low bed as an intervention. Interventions are based around the PALS, what the PALS can observe and monitor. I cannot remember R7's interventions. Transition meetings are weekly, to determine residents that are not fit to continue residing in the facility. There are no residents residing in the facility that are not appropriate. Transition meetings involve the DRCS, Executive Director, Assistant Executive Director, Memory Program Coordinator, Physical Therapy, and Sales team. Updated interventions are documented on Fall Review sheets. Those residents that have had extensive falls, transitioned to a higher level of care are being discussed at the transition meetings. What we are trying different due to all R7's falls is, R7 has a floor alarm, alteration to mattress (barrier placed). We don't have care plan meetings. We have had a transition meeting for R7 because of R7's falls with the DRCS, Executive Director, Assistant Executive Director, Director of Physical Therapy, Memory Program Coordinator. I have not reached out to the provider regarding R7's frequent falls. If the decision is made that the facility is no longer appropriate, we would reach out to the provider.

According to list "Resident Move-In Date" provided by facility on 2/15/2024, R7's move-in

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S9999	Continued From page 22 date was 8/1/2022. Facility Reported Incident, 11/2/2023, documents in part: R7 was sitting in wheelchair in common area. Resident was lethargic and began to fall asleep. R7 fell forward hitting left upper forehead on the wall. Nurse assessed and noted bruising and small bump on left upper forehead. 911 called and resident transported to hospital. R7's progress note, 11/1/23, 3pm, documents in part: Resident was very lethargic after medications. Resident was falling asleep in wheelchair slowly leaning forward. R7 leaned too much and left forehead hit the wall and R7 fell to the floor. Sent out 911. R7 Fall Risk Assessment, dated 11/9/no year provided, indicates R7 total score is 10, high risk. R7 Fall Review, 11/1/23, documents in part: Resident was sitting in wheelchair very lethargic. R7 was falling asleep and leaning forward. R7 leaned too much, and head hit the wall and fell out of chair. R7's PAL (Patient Assistant Liaisons) Approach Chart and Service Plan that includes Resident Care Plan for November 2023 (month that R7 fall occurred) and December 2023 indicate no updates following R7 fall on November 1, 2023. According to list of R7 falls within a period of six months, provided by facility on 2/14/2024, R7 has had five falls. According to R7 progress notes reviewed for a six-month period, R7 has had 13 falls. On 2/15/24 at 3:15 PM, V1 (Executive Director)	S9999		

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S9999	Continued From page 23 stated we do not have a monitoring/supervision policy. R5's Fall risk assessment dated 8/15/2023 documents moderate risk score 5-9 resident scored a 7 and requires use of assistive device (walker). R5's Nurses' notes dated 9/11/2023 7:00am documents R5 reported to nursing staff that she fell in her room. Writer was not notified that the resident fell. Head to toe assessed no visible injury noted. R5 states, "I hit my face on the side" no marks or swelling noted. Writer asked caregiver did resident fall caregiver reported that resident fell at 5:45am and she got herself up from the floor. I instructed caregiver that she must notify staff if resident falls and never get resident off the floor. Left message with daughter and MD/medical doctor. Endorsed to oncoming nurse to follow up. No Physician communication for 9/11/2023. R5's Fall Review dated 9/11/2023 documents a witnessed fall by private caregiver. Intervention added to plan of care /service plan Interventions documents to educate resident on safety measures, clear clutter, encourages to ask for assistance, refer to pt-evaluate, escort assistance, ensure walker, consult pharmacy for high-risk med review, provide nonskid footwear and ensure footwear fits. Nurses note dated 9/24/2023 2:35pm Resident had a fall while trying to ambulate around other residents and tripped over her feet no injury. R5 Fall review dated 9/24/2023 documents notification and communications to MD and	S9999		

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responsible party. Interventions documents, educate resident on safety measures. Encourage resident to ask for assist, ensure clothes are right size/length, refer to PT-evaluate, nursing evaluation: pain dizziness, confusion, weakness, sob/shortness of breath, balance, orthostatic hypotension. List any potential contributing factors: re-evaluate the throw rugs. Physician communication sheet dated 9/24/2023 documents Resident had a fall while trying to ambulate around other residents and tripped over her own feet no injuries noted resident denies pain.

Nurses note dated 10/6/2023 3:00am documents writer alerted by PAL that resident was on the floor due to fall. Upon entering room writer found resident sitting up facing her door, noted with bleeding open wound to L/left side of forehead noted puddle of blood on floor beside resident. Resident alert and talkative, very anxious, first aid rendered by writer. Per caregiver resident was walking in her room loss balance slipped on rug and fell hitting her head on the corner of the cabinet and drawer of cabinet. 911 called immediately resident sent out to local hospital. MD and POA notified.

Physician communication sheet documents dated 10/06/23 2:40am documents Resident(R5) fell in her room hit head open wound bleeding and swelling slipped on rug sent to ER via ambulance.

On 2/15/2024 at 3:38pm at V26 (caregiver) states, my client got up in the middle of the night trying to leave her room. I tried to redirect her which was unsuccessful. R5 loss her balanced and slipped on rugs hitting her head on the corner of a cabinet. I didn't get her off the floor I immediately called the nurse for help. The nurse

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S9999	Continued From page 25 came I told her what happened, she sent the resident out to the hospital, R5 was bleeding and had a head injury. I reported fall to my manager at (name of caregivers employer) . After fall I got a call from the V22 about two days later telling me not to report to work. I was suspended because R5 stated I pushed. They did investigation and when completed I was reinstated and returned to work with same company. Fall Reduction Prevention Policy documents(undated) documents in part: All residents will be assessed for risk of falls just prior to, or at the time of, move-in, and periodically at the discretion of the DRCS. Resident care plan with individualized interventions to help mitigate the risk of injury from falls will be included for those residents at risk. The care plan will be updated with fall management interventions, as appropriate. Take note of environment surroundings to identify potential contributing or extrinsic factors that may need modified as part of individualized preventative measures. Facility failed to follow interventions in R5's Fall's Care Plan dated 9/11/2023,9/24/2023 to clear clutter and re-evaluate rugs in unit which caused R5 to fall documented 10/06/2023 resulting in sustaining an open wound to left forehead. R7 and R3 also affected due to repeated falls resulting in head injuries. (A) Statement of Licensure Violations 2 of 2: 330.4240f) Section 330.4240 Abuse and Neglect	S9999		

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f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act).

This requirement is NOT MET as evidenced by:

Based on interview and record review, the facility failed to ensure that a resident remain free from abuse, for one of three (R2) residents reviewed for abuse. This failure resulted in R1 striking R2 on the left side of her face and R2 developing a bump and experiencing a headache.
Findings include:

R2's current face sheet documents R2 is an 81-year-old individual admitted to the facility on 1/20/2022, and R2's medical diagnosis includes but not limited to: Anxiety, Dementia, Hypertension.

On 2/13/2024 at 11:41am, R2 was observed in the unit's day room sitting in group. When asked if R2 has been abused/hit by another resident, R2 was not able to answer and looked confused. V7(Memory Care Coordinator) was present and stated R2 has memory issues and forgets easily.

R2's progress notes dated 11/12/2023 at 2:30pm documents R2 was in the hallway outside of restroom area, when another resident (R1) struck her on left temple with closed fist. Resident (R2) C/O(complained) of headache. R2 was sent out

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S9999	Continued From page 27 to a community hospital for further evaluation CT/computed tomography SCAN for injury of head and CT Scan of cervical Spine No contrast done, Results pending. R2 returned to the facility later in the evening at 9:35pm. R2's MDS (Minimum Data Set) -COGS Score sheet dated 8/7/2023 documents R2 has a score of 6=lo-moderate with more impairment. Physician communication note dated 11/13/2023 documents R2 was struck on (L) temple with closed fist by another resident (R1). R2 is being sent to ED (Emergency Department) for C/O (complaint of) headache. Facility Reported Incident Report (FRI) dated 11/13/2023 documents: -R2 was ambulating in wheelchair after exiting bathroom. As she attempted to maneuver around R1, she (R2) was struck in the left temple by R1. -V13(Licensed Practical Nurse) assessed R2. R2 was alert and awake. V13 noted bump to left temple and R2 complained of headache. 911 called and R2 was sent to near hospital. R2's hospital records dated 11/12/2023: 1. Head Injury 2. Head Injury with sleep monitoring -You have a head injury. It doesn't appear serious at this time. But symptoms of a serious problem, such as a mild brain injury (concussion) or bruising or bleeding in the brain, may appear latter. R1's current face sheet documents R1 is an 81-year-old individual admitted to the facility on 3/11/2020, and R2's medical diagnosis includes but not limited to: Anxiety, Dementia, Hypertension.	S9999		

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S9999	Continued From page 28 Facility reported Incident report dated 11/13/2023 documents: -Nurse (V13-Licensed Practical Nurse) was alerted by staff that R1 had punched R2 in the head -Nurse(V13) found R1 agitated and pacing in the hallways. R1 monitored by 1:1 caregiver. R1 has no order for PRN (As needed) medication. Tylenol given for possible pain. R1 calm but continued pacing per baseline accompanied by 1:1 caregiver. Care giver escorted R1 away from other residents to area where she was calm and laid down for short period of time. Upon waking up, R1 remained agitated. R1 was removed from area. R1's progress notes dated 11/12/2023 at 2:30pm documents: Resident(R1) agitated, struck another resident (R2) with closed fist at (L) temple. No PRN (as needed) medication another than Tylenol available. Resident (R1) is still pacing the hallway. Fax communication sent to MD (Medical doctor). R1's progress notes dated 12/12/2923 at 4:10pm: Resident(R1) remains agitated. Awake from nap and attempted to strike another resident. V7(Memory Care Coordinator) called POA (Power of Attorney) and R1 sent out to community hospital for evaluation. R1's progress notes dated 11/15/2023 at 7:30pm documents: Resident (R1) up, AOX1(alert and oriented times one) verbally responsive. After dinner, R1 started to get agitated. PRN given and effective. Physician Communication note dated 11/23/2023 documents: Increase Quetiapine 50mg to 100mg PO (by	S9999		

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S9999	Continued From page 29 mouth) QAM (morning)for dementia with behaviors -POA approved. R1's hospital records dated 11/12/2023 documents: -R1 was seen at the community hospital for aggressive behavior due to dementia. On 2/13/2024 at 11:46am, V7(Memory Program Coordinator) said she was aware of R1 and R2's altercation, and that R2 was coming out of the common area bathroom when R1 hit R2 on the face by the left chick. V7 said R2 was sent to a nearby hospital for evaluation, and R1 was also sent out for assessment for aggressive behavior. V7 said V9(Personal Assistant Liaison -PAL) was in the area when R1 struck R2. V7 said R1 was agitated that day, about 20 minutes before she hit R2. V7 said she evaluates the memory cognation of the residents in the memory care units. V7 and surveyor reviewed R1's MDS -COGS Score sheet dated 8/7/2023 which documents R1 has a score of 7=lo-moderate with more impairment. V7 said R1 has memory impairment and speech difficulties and needs redirection. V7 and surveyor reviewed R2's MDS -COGS Score sheet dated 8/7/2023 documents R1 has a score of 6=lo-moderate with more impairment. V7 said R2 has memory impairment and does not remember things and gets anxious especially near people she does not know. V7 said residents should not hit each other even when they are in the memory care unit, and R2 was affected physically at the time R1 hit her, but R2 and R1 do not remember the incidence. V7 said R1 was put on 1:1 supervision after the incident to monitor behavior of aggression for two weeks post hitting R2. V7 said since this is sheltered care/assisted living, residents are not on 1:1 monitoring.	S9999		

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S9999	Continued From page 30 On 2/15/2024 at 3:57pm, V2 (Director of Resident Care) said the facility did not receive the CT scan results for R2 after R2 was sent to the hospital for further evaluation after being hit by R1. V2 said without the results of the CT scan, the staff did not know what type of injury R2 suffered, but V2 said the nursing staff followed the instructions from the hospital which stated: 1. R2 had head injury, 2. R2 had head injury with sleep monitoring. V2 said residents should not be hitting each other and should feel safe at the facility, and nursing staff should monitor residents to keep them safe. V2 stated R2's head injuries did not appear to be serious per the discharge instructions from the hospital. V2 said if R2's physician had been able to obtain the CT scan results from the hospital, it should be documented in R2's chart so that nursing staff can know what type of care and extent of head injury R2 obtained. V2 stated he has sent a fax today, 02/15/2024 to the community hospital requesting the CT scan results for R2 and has not received the results yet. On 2/13/2024 at 2:224pm, V9(PAL- Personal Assistant Liaison) said R2 was coming out of the common bathroom located near the elevator inside the unit, and R1 was standing outside the bathroom in the hallway, waiting to go to the bath. V9 said he was near R1 waiting to assist her in the bathroom, and as R2 was passing by R1, V9 said he saw R1 hit R2 on the left side of the face and R2 said to R1"Did you just hit me?" V9 said R2 might have got in the way of R1, but V9 does not know how or why R1 hit R2. V9 said he notified the nurse on duty V13 (Licensed practical Nurse-LPN) about the incident and V9 said he did not see any injury on R2 at that time.	S9999		

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S9999	Continued From page 31 On 2/14/2024 at 4:02pm, V15 (Personal Assistant Liaison-PAL) said she has worked at the facility for two years and seven months and she works on the 2nd floor most of the times, and she was working on the day when R1 hit R2, but she did not witness it but heard from her co-workers that R1 had struck R2 on the face. V15 said after the incidence, she saw R2 and R2 had a small bump on the forehead. On 02/15/2024 at 10:40am, V23 (Personal Assistant Liaison -PAL) said the PALS watch R1 closely because she likes to touch things and might touch other resident's stuff. V23 said residents are not allowed to hit each other, and residents should be safe at the facility. V23 said staff (PALS) should monitor residents to prevent residents from hitting each other. On 02/14/2024 at 3:47pm, and 02/15/2024 at 9:40am, calls placed to V13(Licensed Practical Nurse-LPN). No answer. V13 unable to be reached. Facility policy titled Elder Abuse dated 9/2023, 2/2024 documents: -Each resident, (adult or child) has the right to be free from mistreatment, neglect, and misappropriation of property. This includes the facility's identification of residents, whose personal histories render them at risk for abusing other residents, and development of intervention strategies that include screening, training, prevention, identification, investigation, protection and reporting to prevent occurrence, monitoring for changes that would trigger abuse behavior, and reassessment of the interventions on a regular basis. -physical abuse is defined as hitting, slapping, pinching, kicking, etc. It also includes controlling	S9999		

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S9999	Continued From page 32 behavior through corporal (bodily) punishment. (B)	S9999		