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S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999		

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resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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

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

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

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Regulations are not met as evidenced by:

Based on interview and record review the facility failed to fully investigate resident falls, failed to

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perform a root cause analysis of the falls, and failed to develop and implement appropriate interventions to prevent future falls for 3 of 13 residents (R21, R2, and R27) reviewed for falls in a sample of 31. This failure resulted in R21 falling and sustaining a facial laceration with sutures, nasal bone fractures, and a nondisplaced fracture of the left middle finger.

Findings include:

1. R21's New Admission Information Sheet documents an admission date of 05/15/2019. R21's Cumulative Diagnosis Log (undated) documents diagnoses including: Advanced Dementia, Altered Mental Status, Alzheimer's Disease, closed fracture of ramus of right pubis, closed compression fracture of body of L1 vertebra, closed left arm fracture, and Pelvic ring fracture, decreased Mobility. R21's MDS (Minimum Data Sheet) dated 12/04/23 documents no BIMS (Brief Interview of Mental Status) was conducted due R21 is rarely understood.

R21's Fall Risk Assessment dated 10/21/23 documents a score of 15, this document notes "10 points or more = high risk score".

The facility document titled. "Fall Analysis Log" dated February documents R21 had falls on 2/12/24, the one dated January notes a fall on 01/28/24, the one dated November notes a fall on 11/05/23 and the log dated October documents falls on 10/15/23, 10/21/23, and 10/23/23.

On 03/06/24 at 10:30 AM, V1 (Administrator) stated the documents titled, "Quality Improvement Review" are the fall investigations for the residents.

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R21's Quality Improvement Review dated 02/12/24 at 8:30 AM documents: Resident (R21) was observed walking in the hallways. She was wearing her non-skid socks. She (R21) was then noted sitting on her buttocks in the hall. No environmental issues noted. Resident (R21) has decreased safety issues and will reach out for others. Assessed at the ER (Emergency Room). (R21's) BIMS (Brief Interview of Mental Status) is 3. Intervention is to have 15 minute visual checks and frequent monitoring.

On 03/07/24 at 2:00 PM, V1 (Administrator) stated, from that fall investigation (fall occurring on 2/12/24) she could not tell what the root cause of the fall was, if R21 was injured, what an appropriate intervention would be and there was no interviews done in relation to the fall from other residents or staff.

R21's Nurse's notes dated 02/12/24 at 6:15 PM documents "noted res (R21) sitting upright on floor in hallway. Raised goose egg erected to left forehead. The area is purple and bleeding. R21 moves head and neck freely. C/O (complaints of) pain to left forehead only. ROM (Range of Motion) WNL (Within Normal Limits) for this resident. Assist res (resident) to stand. Ambulated to her own room (without) difficulty. Continue to require pressure to forehead d/t (due to) continued bleeding." R21's Nurses Note dated 2/12/24 at 6:45 PM documents "called EMS (Emergency Medical Service) for request to transfer."

R21's Nurse's notes dated 02/13/24 at 1:35 AM documents: Resident (R21) returned to facility per wheelchair and staff. R21 is cheery and slightly confused, she has a dressing to her forehead

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S9999	Continued From page 4 containing 2 to 3 sutures. R21's hospital records dated 02/12/24 document: Diagnosis: Unspecified injury of head, initial encounter; Laceration without foreign body of other part of head. Discharge Instructions: Head injury, Facial Laceration. Follow up instructions: Reason: staple/suture removal, return to ED (Emergency Department) or have sutures removed by your physician in 5-7 days. R21's Quality Improvement Review dated 01/28/24 at 8:35 AM documents: This resident (R21) was ambulating in the hallway before this event occurred. She has complaints of aching afterward. She has decreased safety awareness and her BIMS is 3. The intervention is to educate staff on checking residents for proper footwear/non-skid socks, monitor frequently and encourage resident to ask for assistance/offer assistance. On 03/07/24 at 2:00 PM, V1 (Administrator) stated, from that fall investigation (fall occurring on 1/28/24) she could not tell what the root cause of the fall was, if R21 was injured, if she was sent out for evaluation, if that was an appropriate intervention for this fall and there were no interviews done in relation to the fall from other residents or staff. V1 stated, R21 would be assisted with her footwear by staff and R21's care plan documents an intervention on 10/23/23 of: R21 to wear nonskid socks during ambulation on the unit, so that would also be a duplicate intervention. R21's Nurse's notes dated 01/28/24 at 9:25 AM document: Resident (R21) fell in hallway in a cubby area where she was not seen. Another resident found her and reported it to one of the	S9999		

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aides. She was found sitting up leaning on the wall, blood coming from her nose, hematoma on her forehead on the right side. She has a laceration on her nose. R21 states she does not know what happened. R21 was sent to ER for evaluation.

R21's Social Service Progress Notes dated 01/29/24 document: Resident (R21) fell yesterday 01/28/24. Another resident found her and reported it. She was bleeding from the nose. Sent to ED. R21 has a broken nose and bruising all over face.

R21's Social Service Progress Notes dated 02/01/24 document: Resident (R21) still has bruising on her face. Says it hurts a little but not complaining. Ambulates around on her own and can have an unsteady gait from time to time. Can communicate but jumble words when speaking. She can still make her needs known. BIMS 3, her focus isn't the best.

R21's Nurse's notes dated 01/30/24 at 8:48 AM document: Bruising noted to both sides of face.

R21's Emergency Department records dated 01/28/24 document: CT (Computed Tomography) Maxillofacial: There are bilateral mildly depressed nasal bone fractures. There is chronic appearing rightward deviation of the nasal septum, however there is also likely a mildly displaced fracture through the posterior septum with 2 to 3 mm (millimeters) displacement. Impression: 1. Right frontal scalp hematoma. No acute intracranial abnormality. 2. Bilateral mildly depressed nasal bone fractures. 3. Probable mildly displaced fracture through the posterior nasal septum.

R21's Quality Improvement Review dated

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S9999	Continued From page 6 11/05/23 at 4:15 PM documents: Resident (R21) was ambulating in the east dining room with her non skid socks on. She appeared to trip before this event. She was seen in the ER for complaints of left hand wrist discomfort. She has decreasing safety awareness. Intervention is to have a PT (Physical Therapy) evaluation. On 03/07/24 at 10:30 AM, V24 (Physical Therapy Director) stated R21 was already receiving occupational therapy from 10/11/23 to 12/06/23 and physical therapy from 11/15/23 to 12/29/23. R21's Nurse's notes dated 11/05/23 at 4:15 PM documents: R21 was seen tripping over another resident's chair and fell to the floor. R21 attempted to catch self resulting in skin tear on left hand and left middle finger. Complaints of pain to left hand and steri strips applied to areas on hand. At 4:30 PM R21 will not sit down in dining room, continues to wander. Multiple attempts have been made by staff to help direct resident to seat. R21's Nurse's notes dated 11/5/23 at 9:09 PM documents that R21's middle finger on left hand is blue inf color and R21 was sent to the local hospital for evaluation and treatment. R21's Nurse's notes dated 11/05/23 at 8:49 AM document: Resident (R21) in room for breakfast. She sat up on the side of the bed to eat breakfast tray. R21 took AM medications with difficulty. Bruising and swelling noted to R21's left hand. On 37/24 at 11:00 AM, V8 (Licensed Practical Nurse) stated, she would have to guess the note dated 11/05/23 at 8:49 AM should be 11/06/23 at 8:49 AM.	S9999		

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R21's Hospital notes dated 11/05/23 document: Diagnosis: Fall on same level, unspecified, Contusion of other part of head, contusion of hand. Discharge instructions: Hand contusion, Head injury.
R21's Nurse's Note dated 11/8/23 at 11:25 AM documents "New x-ray orders for L (left) hand and wrist."

R21's Nurse's note dated 11/9/23 at 9:50 AM documents "Received results of X-ray on 11/8/23, NP (Nurse Practitioner) notified and wanted her sent to ER (Emergency Room). She was sent to (name of local hospital) ER. Before leaving she c/o mild pain and not being able to move fingers on L hand. No c/o pain anywhere else besides her hand. Currently at ER (with) CNA (Certified Nurse's Assistant) from facility."

R21's Hospital notes dated 11/09/23 document: Diagnosis: Non-displaced fracture of distal phalanx of left middle finger. Discharge Instructions: Finger Fracture; Follow up instructions: When - 5 to 6 days, reason - worsening of condition; Recheck today's complaints.

R21's Imaging Report dated 11/9/23 documents: Exam Reason: pain with trauma/injury. Discussion: The bones are diffusely demineralized. There is possible recent intra-articular fracture involving the proximal aspect of the third digit middle phalanx. Which can be correlated with the clinical situation. Osteoarthritic changes are most severe in the first carpometacarpal joint region. Impression: 1. Possible recent fracture involving the proximal aspect of the third digit middle phalanx, can correlate with the clinical situation. Emergency Department records dated 11/9/23 note: at 11:06

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AM This 87 year old white female presents to ER with complaints of fall injury. 11:06 AM The patient (R21) or guardian reports injury. The complaints affect the left hand diffusely. Context: The problem was sustained at a nursing home or assisted living facility, resulted from a fall. Onset: The symptom(s)/episode began/occurred acutely. Modifying factors: the symptoms are aggravated by movement. Associated signs and symptoms: Pertinent positives: swelling, Severity of symptoms: in the emergency department the symptoms are unchanged. It is unknown whether or not the patient has had similar symptoms in the past. It is unknown whether or not the patient has recently seen a physician, 87 year old lady with Dementia who sustained injury to left hand from a ground level fall a few days ago. She has no other complaints. She has associated swelling of the digits. She denies headache, denies neck and back pain. Diagnosis: Nondisplaced fracture of distal phalanx of left middle finger.

R21's Quality Improvement Review dated 10/23/23 at 4:15 PM documents: Resident (R21) has independent ambulation and decreased safety awareness. She was in the east dining room but had removed her nonskid socks when this event occurred. R21's BIMS is 3. Intervention is to educate staff to encourage resident to put her socks on and leave socks on for safety when walking.

R21's Nurse's Notes dated 10/23/23 at 4:15 PM document: R21 was on the floor in dining room. R21 was sitting on her bottom in front of the table she had been sitting at.

R21's Nurse's Notes dated 10/24/23 at 12:00 AM documents: R21 is up to Nurse's station with complaints of right rib cage pain and bruising

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noted.

R21's Quality Improvement Review dated 10/21/23 at 3:38 PM documents: Resident (R21) has decreasing safety awareness and independent ambulation. She was in the east dining room and appeared unsteady. She was wearing her nonskid socks. She has a BIMS of 3. Intervention for this event is to have a therapy evaluation.

R21's Nurse's Note dated 10/21/23 at 4:00 PM documents: Resident (R21) found on the floor by another resident's family. R21 stated, "that man pushed me" however the man that she was pointing to was a female. A male resident was witnessed attempting to help R21 from the floor and a female resident was hovering behind her. The family member of the other resident helped R21 from the floor and brought her to the nursing station. X-ray of right shoulder, wrist and hip were ordered and awaiting approval.

R21's "Patient Report" from the mobile X-Ray company dated 10/22/23 document Reason: Fall on right side with pain within the shoulder, wrist and hip areas. Findings: No acute fractures or dislocations are noted. Chronic fracture deformity of the distal radius is identified. An ulnar positive variance is noted. Moderate degenerative changes are present. The surrounding soft tissues are normal.

On 03/07/24 at 2:00 PM, V1 (Administrator) stated, from the 10/21/23 fall investigation she could not tell what the root cause of the fall was, if R21 was injured, what an appropriate intervention would be and there was no interviews done in relation to the fall from other residents or staff. She stated from the fall investigation it sounded

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like the fall was witnessed but the nurse's notes stated she was found by another resident's family member, which strongly suggests it was an unwitnessed fall. V1 stated, she does not know why the intervention was to have a therapy evaluation, since she was already on therapy. The intervention of wearing nonskid socks during ambulation would not be helpful when the Quality Improvement document states she has them on.

On 10/15/23 at 6:15 PM R21's Quality Improvement Review documents: This ambulatory resident (R21) was observed in the bathroom. She was trying to use the bathroom by herself. She did have her gripper socks on and was sitting on her buttocks in front of the stool. No environmental factors. R21 is on antidepressant medications and antihypertensive medication. She has decreasing safety awareness. Intervention is to educate staff to encourage resident to ask for assistance in the bathroom.

There is no documentation of this fall in the nurse's notes.

On 03/07/24 at 2:00 PM V1 (Administrator) stated, from that fall investigation (for the fall occurring on 10/15/23) she could not tell what the root cause of the fall was, if R21 was injured, what an appropriate intervention would be and there was no interviews done in relation to the fall from other residents or staff. V1 stated with R21's cognition level she would not remember very long to ask for assistance in the bathroom, so that is not an appropriate intervention. V1 stated, R21's MDS (Minimum Data Set) documents she is assessed as needing assistance to the toilet and supervision with locomotion.

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R21's MDS dated 03/08/23 documents toilet use: Limited assistance - resident highly involved in activity, staff provide guided maneuvering or limbs or other non-weight bearing assistance with one person physical assistance, and for locomotion on unit as supervision - oversight, encouragement or cueing with setup help only.

R21's care plan with a category of Falls documents: Resident (R21) has periods of poor safety awareness where she does not pay attention to surroundings and location of objects around her. Risk factors include: forgetfulness and episodes of confusion and poor safety awareness. Current cognitive level is alert and oriented x3 with episodes of forgetfulness with a start date of 08/16/21. Interventions documented include: Remind of safety precautions and limitations as necessary with a start date of 08/16/21, frequent reorientation and reminders on location of room and surrounding with a start date of 08/16/21, staff are to assist resident to bathroom during HS (evening) and when they see resident attempting to use restroom without assistance. PT/OT (Physical therapy/occupational therapy) to evaluate for safety and gait training. 10/23/23, resident unsteady with gait. Will have therapy see if can do evaluation with a start date of 10/27/23, and R21 had fallen due to other resident's chair, balance and weakness noted and will benefit from therapy evaluation with a start date of 11/10/23. There is no documentation on R21's Care Plan for interventions implemented after R21's fall on 10/15/23 and 1/28/24.

2. R2's New Admission Information sheet documents R2 has an admission date of 04/22/19. R2's Cumulative Diagnosis Log documents diagnoses including: Dementia, Generalized anxiety disorder, Alzheimer's

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disease, Irritable Bowel Syndrome, and Macular Degeneration. R2's Minimum Data Sheet dated 10/9/23 documents active diagnoses including: Unsteadiness on feet, Muscle Weakness, and other Reduced Mobility.

The facility document titled "Fall Analysis Log" dated February 2024 documents R2 had falls on 2/1/24, 2/13/24, and 02/14/24. The January 2024 "Fall Analysis Log" documents that R2 had falls on 01/08/24, 01/13/24, and 01/29/24. The November 2023 "Fall Analysis Log" documents that R2 had falls on 11/02/23, 11/07/23, 11/16/23, 11/21/23, and 11/24/23.

R2's Fall Risk Assessment dated 02/01/24 documents a score of 8 with a reference of "10 points or More = High risk Score." Under the section "History of Fall Last 3 Months" and answer of "0" is documented, indicating that R2 has no known history of falls.

R2's Quality Improvement Review dated 02/13/24 at 12:00 AM documents: Resident (R2) was at the east nurse's station and had been sitting on her walker seat. She attempted to stand up and fell to the floor. BIMS 99 (indicating severely impaired cognition). Intervention is to encourage resident to ask for assistance from staff.

On 03/07/24 at 2:00 PM, V1 (Administrator) stated, R2's Fall Risk Assessment dated 02/01/24 is incorrect, the category "History of Fall Last 3 Months" documents zero falls for a point assessment of 0, she stated she can see where she has had eight falls in the last three months which would be a point value of 5, which would give her a score of 13, which would make her a high fall risk. She stated, she does not know why it got filled out incorrectly. V1 stated that R2

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would not remember to ask for assistance if told to for very long because of her cognitive limitation, so the intervention of encourage R2 to ask for assistance from staff was not an appropriate intervention and R2 is already assessed as needing assistance. V1 also stated there is no documentation stating whether the physician was notified.

There is no nurse's note regarding the fall on 02/13/24.

R2's Quality Improvement Review dated 01/29/24 at 1:00 PM documents: Resident (R2) has very poor vision, uses a wheeled walker, takes psychotropics and antidepressants on a routine basis. She is non-compliant with asking for any assistance. She can become agitated very easily. Resident (R2) was by the east nurse's station with her walker when this event occurred. She had a skin tear to the left shin and a reddened area to the left elbow. No further complaints. She had on proper footwear but did not indicate she needed help changing positions. Intervention is to always use the wheeled walker, proper footwear and encourage her to accept staff assistance with ADL's (Activities of Daily living). She has a very poor safety awareness.

R2's Nurse's notes dated 01/29/24 at 1:50 PM document: Resident (R2) had a witnessed fall at 1:00 PM R2's walker caught on furniture when trying to turn around by nurse's station and resident lost her balance resulting in fall. R2 did not hit her head. R2 has complaints of left elbow pain. There is a bruise noted and a skin tear to left shin noted. Steri-strips applied.

On 03/07/24 at 2:00PM V1 (Administrator) stated, from the documentation of the fall investigation

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(for the fall occurring on 1/29/24), (the Quality Improvement Review) it sounds as if R2 had been using a wheeled walker, had proper footwear on, and it notes that she is non-compliant with asking for assistance. V1 stated, she does not believe there is a new intervention included on the fall investigation or an appropriate intervention. V1 stated, R2's care plan does not document any intervention for the fall on 01/29/24.

R2's Quality Improvement Review dated 01/13/24 at 11:00 AM documents: This resident (R2) has poor vision, decreasing safety awareness, reluctance to ask for assistance with anything. She is on psychotropics and antidepressants. She is non-compliant with staff encouragement to allow assistance with ADL's. She can also become easily agitated and is forgetful. This event occurred in the bathroom where resident was attempting to sit on the toilet and missed. Correct footwear and interventions were in place. No injuries. BIMS 99. Intervention is to toilet her with any request as she allows assistance.

R2's Nurse's notes dated 01/13/24 at 11:00 AM documents that resident (R2) was found in restroom on knees. R2 states, "I hit my head." Neurological checks were initiated and were within normal limits for resident. Fall report filled out.

On 03/07/24 at 2:00 PM, V1 (Administrator) stated, an intervention of toilet her with any request is not an appropriate intervention, she should be toileted upon request, and she is assessed to need assistance with toileting. V1 stated R2 has a previous intervention to have assistance with toileting. V1 stated that the fall investigation documents she is non-compliant

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S9999	Continued From page 15 with asking for assistance. R2's Quality Improvement Review dated 01/08/24 at 9:55 AM documents Resident (R2) has a wheeled walker, poor vision, and is on psychotropics and antidepressants. She is non-compliant with asking for help and /or accepting assistance. This event happened in the hallway while resident was using her wheeled walker. Intervention is to continue to encourage resident to accept assistance and educate staff to approach her up to five times to offer assistance. On 03/07/24 at 2:00 PM, V1 (Administrator) stated, from the Quality Improvement Review (from the fall occurring on 1/8/24) you cannot tell what happened in the fall, if there were any injuries, what the root cause of the fall was and if that intervention would be an appropriate intervention. There is no documentation of the fall on 01/08/24 in the nurse's notes. R2's Quality Improvement Review dated 11/21/23 at 6:15 PM documents: Resident (R2) was observed to fall while trying to get to bed. She had her nonskid socks on but has decreasing safety awareness. BIMS 99. The intervention is to assist her with ADL's. R2's nurse's notes dated 11/21/23 at 6:15 PM documents: V26 (Registered Nurse) was walking by R2's room and noted R2 was lying on her right side on the floor beside the bed. R2 stated, "I bumped my head" Small raised area noted to back of head. No other injury noted. On 03/07/24 at 2:00 PM, V1 (Administrator) stated, she does not know how the fall	S9999		

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investigation (for the fall occurring on 11/21/23) documents that R2 was observed falling and the nurse's note documents R2 was found on the floor. V1 stated there are some discrepancies between the two accounts of the fall, she does not know why.

R2's Quality Improvement Review dated 11/16/23 at 11:30 AM documents: Resident (R2) has poor vision and a decreasing safety awareness. She uses a wheeled walker. She ambulated from her room to the bathroom where she attempted to sit on the toilet seat. She missed the seat and went to the floor. She did have her nonskid socks on but is non-compliant with asking for assistance on a regular basis. Intervention is to have a therapy evaluation. R2's BIMS is 99.

R2's Nurse's notes dated 11/13/23 at 2:00 AM documents: R2 fell in the bathroom trying to sit on the toilet. The aide who was helping her turned around for a pull up to help her change and R2 missed the toilet and fell on her bottom in front of the sink next to the toilet. R2 bumped her head on the toilet but has no injuries.

On 03/07/24 at 2:00 PM, V1 (Administrator) stated that she does not know who the aide was, and the fall investigation (for the fall occurring on 11/13/23) does not document an aide present, the aide should not have turned around until R2 was seated, especially with R2's poor eyesight.

R2's care plan documents a section for Falls with a start date of 05/12/2019 and a Goal of: Resident/responsible party will be able to state potential consequence of self-transfer/ambulation and state why still prefers self-care thru next CP (care plan) review with a date of 12/06/21. The intervention documented on 11/17/23 is Therapy

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evaluation, and the intervention documented on 02/13/24 is: encourage resident (R2) to ask for assistance.

3. R27's Face Sheet documents an admission date of 11/2/2022. R27's POS (Physician's Order Sheet) dated 2/1/2024 through 2/29/2024 documents R27's has been diagnosed with Hemiplegia following Cerebral Infarct affecting left side, Type 2 Diabetes Mellitus, Essential Hypertension, Need for Assistance with Care, Depression, Urinary Retention, Cognitive Impairment and Right Internal Carotid Thrombosis. R27's MDS (minimum data set) dated 11/21/23 documents R27 was assessed with BIMS (Brief Interview for Mental Status) in which R27 scored 13 out of 15 total and indicates R27 is cognitively intact. Fall Risk Assessment for R27 dated 2/15/2024 documents R27 is a high fall risk.

On 3/5/2024 at 11:15am, R27 said he fell a few times at this facility.

A Nurse's note in R27's medical record and dated 2/15/2024 at 7:45pm and entered by V25 (Registered Nurse/RN) documented the following: Resident yelling for son from room. Went to room, resident on floor on back with feet still up on bed. Very confused, thought he was in a car and thought son was in room. Informed NP (Nurse Practitioner) on call and orders received to send to local emergency room for evaluation. Nurse's note in R27's medical record and dated 2/15/2024 at 11:00pm documented R27 returned from the emergency room with negative CT scan (computed tomography).

On 3/7/2024 at 3:00pm, V25 (Registered Nurse) said R27's psychotropic medications had been

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increased. V25 said on 2/15/2024, R27's psychotropic medication administration times were changed from R27 receiving Quetiapine 100mg (anti-psychotic) at bedtime to R27 receiving Quetiapine 100mg at 4:00pm. V25 said on 2/15/2024 she administered R27's Quetiapine 100mg at 4:00pm and at 5:45pm, R27 had fell. V25 said she heard R27 yelling and went to see what was going on. V25 said she seen R27 laying on the floor on his back but still had his feet up on the bed. V25 said R27 was sent to the local emergency room to be checked for injuries from his fall, but none were found and R27 was diagnosed with a urinary tract infection.

Local hospital emergency room records dated 2/15/2024 document R27 was diagnosed with a urinary tract infection and did not document anything about R27 being seen for possible fall injuries.

On 3/7/2024 at 10:00am, V2 (Director of Nursing) said R27 had an unwitnessed fall on 2/15/2024 and she performed the fall investigation.

V2 submitted a facility form titled Quality Improvement Review and dated 2/15/24 at 1745 (5:45PM) as written documentation of the fall investigation she performed for R27's fall on 2/15/24. This form documented the following: Resident found on floor of his room. When asked what happened he told the nurse he needed to get in his car. Resident has decreased safety awareness and decreased cognitive issues. Uncooperative with BIMS (Brief Interview for Mental Status). New interventions are a floor pad and upper side rail times one.

On 3/7/2024 at 10:00am, V2 said she had not considered the time change/increase of his

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psychotropic medication as being a factor in R27's fall on 2/15/2024. V2 said she did not have any witness statements or other investigation documentation for R27's fall on 2/15/2024 and could not produce documentation of performing root cause analysis for this fall.

A facility policy titled Fall Prevention (last revision date of 11/10/18) documents the following in part: Policy is to provide for resident safety and to minimize injuries related to falls, decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. #5 Immediately after any resident fall, the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. #6 The unit nurse will place documentation of the circumstances of a fall in the nurses notes or on an Aim for Wellness form along with any new interventions on deemed to be appropriate at the time The unit nurse will also place a new intervention on the CNA (Certified Nurse's Assistant) assignment worksheet. #7 Report all falls during morning Quality Assurance meetings Monday through Friday. All falls will be discussed in the morning Quality Assurance meeting and any new interventions will be written on the care plan.

(A)