STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007892	A. BUILDING: _____ B. WING _____	C 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION RESURRECTION PLACE	1001 NORTH GREENWOOD AVENUE PARK RIDGE, IL 60068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigations: 2397985/IL164783 2397388/IL164052	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) 300.1210b) 300.1210d)2) 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. 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	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 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: 2) All treatments and procedures shall be administered as ordered by the physician. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to provide care and services in a timely manner for residents with suspected injuries, who had orders for x-rays and resulted in delay of treatment for injuries. This failure applied to two (R2, R3) of three residents reviewed for resident injury and resulted in R2 and R3 waiting over 24 hours after injury to be transferred to hospital for further evaluation and treatment of fractures. Findings include: 1. R2 was admitted to the facility with diagnoses that include: Parkinson ' s Disease, difficulty walking and gastrostomy tube. Facility provided incident report for incident on 7/28/23, which documented the following: (R2) is AxO (Alert and Oriented) x0. BIMS score of 99. On 7/28/23 around 12:15pm, the resident's daughter notified the nurse that her mother (R2) was yelling when she grabbed her right ankle. Nurse immediately assessed the resident's right ankle and notified the Nurse Practitioner who ordered an Xray of the right ankle. The X Ray results came back on 07/29/23 which showed	S9999		

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S9999	Continued From page 2 acute right ankle fracture and marked osteopenia and DJD of the right ankle. Resident's PCP was notified, and he gave orders to send the patient to (local hospital) for further evaluation and treatment...Facility immediately started an investigation. R2 returned from hospital the same day with orders for CAM Boot to the right foot and recommendations for non-weight bearing of the right lower extremity, and to follow up with an orthopedic clinic in 1 week. As a part of the investigation, we interviewed staff and residents, and conducted a chart review. Staff interviews revealed no noticeable changes to patients' right ankle while providing care prior to 7/28/23. However, staff did note that R2 is impulsive and restless in bed all the time with multiple attempts to exit from the bed ...Conclusion: Based on the patient's diagnosis of primary osteoarthritis of right ankle and foot, disorder of bone density and structure of right ankle and foot, X-ray results from 7/28/23 indicating marked osteopenia and DJD of right ankle, and calcium level of 8.2 on 7/19/23, (R2) is at a higher risk for pathological fractures. Based on the investigation, staff and resident interviews, the facility could not substantiate any type of abuse or neglect...". Nursing Progress Notes document the following: 7/29/2023 7:55 PM Nursing Notes for R2: LATE ENTRTY 7/28/23: At 12:15pm "Patient's daughter approached this charge nurse on duty at nursing station to say that patient is yelling when right ankle is grabbed. Ankle was assessed, at the time no redness, discoloration or swelling noted on ankle. Informed and NP ordered a STAT ray of the right ankle to be performed. Called (x-ray company) portable to put in new order for x ray. Relayed information to	S9999		

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S9999	Continued From page 3 nurse taking care of patient and Manager on duty notified". 7/29/2023 10:03 PM Nursing Notes for R2: LATE ENTRY, at 7:45 am. "X-ray technician came and did x ray to her (R2) right angle. Her vitals are stable (BP-123/78 MMHG, P 76B/M, R 18b/m, temp 98f. At 11am her son came and put her in the wheelchair with the help of the CNA. The POA went to the small dining room with her and fed her lunch ... After two hours (R2) was put back to the bed. The x-ray result came through fax (approx. 1:00 pm 7/29/23). The supervisor paged doctor to inform of the X-ray result, but no response. After that, supervisor called the doctor's phone and informed her of result. Send to the ER for further evaluation. Informed the manager on call and DON by supervisor. Ambulance took her (R2) to (hospital). ER (according to the paramedic she has hypotension on the way to ER) informed the POA also regarding the hospital transfer. The writer gave the report to the ER doctor also". 7/29/2023 11:09 PM Nursing Notes for R2: At 6 pm the writer and supervisor assessed the resident's right ankle. "There is no redness or swelling in the right ankle. Informed the on-call manager and DON also". 7/30/2023 1:47 PM Nursing Notes for R2: "The resident came from (hospital) at 11.15 am via ambulance. Vitals checked (bp 135/80 mmhg, P 81b/m, R 20 b/m, TEM 98 F). Fed lunch, ate 70%. Gave due medication and started the feeding ... She is sleeping in the bed. Boot on the right leg. She has a follow up appointment on	S9999		

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S9999	Continued From page 4 8/6/2023 with her orthopedic surgeon". X-ray report for R2 date of service 7/29/23 documents impression findings of closed acute fractures of the distal tibia and lateral malleolus and marked osteopenia and DJD of the ankle. 2. R3 was admitted to the facility with diagnoses that include: multiple sclerosis, obesity, overactive bladder, and insomnia. Facility provided incident report and investigation documenting that on 9/22/23, R3 was involved in an incident that resulted in a right ankle fracture. Per CNA (V15), that was involved in the incident, on 9/22/23 at approximately 8 PM, while assisting R3 transfer from toilet to wheelchair, the resident had to be lowered to the ground because she was too heavy for V15 to transfer alone and R3 was no longer able to sustain herself while standing. After being placed in bed, R3 notified V15 that she was experiencing pain to her right foot. When V18 (RN) assessed R3's foot, V18 identified pain and swelling. V18 notified the doctor, who ordered an x-ray to be taken. Facility investigation concluded that "based on the investigation, it was noted that (R3) was eased to the floor while she was assisted during transferring from the toilet to the wheelchair. During the process of transfer, she may have twisted her ankle which may have resulted in the right ankle fracture. The facility couldn't substantiate any form of abuse or neglect." Nursing Progress Notes regarding R3 document the following: 9/23/2023 12:47 AM LATE ENTRY 9/22/23 9:30 PM Resident lying in bed complained of pain on right ankle. Resident states she might have twisted her ankle. No	S9999		

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S9999	Continued From page 5 bruise, or redness, swelling is more than the left ankle. Doctor was paged with order to do x-ray of the right ankle and Tylenol 650mg po every 6 hours as needed for pain. 9/23/2023 7:28 AM 11PM- 7AM shift late entry: Patient noted with swelling and tenderness on the right ankle. She verbalized that it is painful when she moves it. No redness, skin intact. Pain/discomfort is alleviated with rest and keeping her leg still. X-ray of right ankle scheduled to be done today. Endorsed to oncoming nurse. 9/24/2023 11:29 AM 1025AM: Followed-up with (x-ray company rep) for right ankle x-ray result. 1040AM: Right ankle X-ray result received with impression acute, displaced trimalleolar fractures with ankle malalignment. Orthopedic consultation is recommended. Relayed to Doctor with order to send to (local hospital) ED for further evaluation and treatment. 10:42AM: Informed resident and she is amenable to be sent to (hospital) ED. 10:47AM: Attempted to call daughter, but phone is not accepting any calls. 10:48AM: Called (ambulance services) - ETA between 20-30 minutes 11:10AM: Called local hospital ED c/o (staff name) - gave report. 11:30AM: EMS 2 persons arrived to pick up resident. 11:40AM: (R3) Left the unit. Addendum 9/24/23 2:16 PM 01415PM: Followed up with (hospital) ED c/o (staff name) - resident admitted with diagnosis of right trimalleolar fracture, closed.	S9999		

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S9999	Continued From page 6 X-ray report for R3 has date of service as 9/23/23 and documents that R3 had an acute, displaced trimalleolar fracture with ankle malalignment of the right ankle; orthopedic consult was recommended. Notation on report reads, "9/24/23 @ 10:40am, Relayed MD send to (local hospital) for eval and treatment." Interview with V18 (RN) on 9/29/23 at 4:11PM, V18 re-affirmed what she documented in her statement and added that the CNA (V15) transferred the resident from the toilet to the wheelchair by herself and that she couldn't do it because the patient is heavy. V18 stated, "There should be two CNA's; (R3) has MS (multiple sclerosis) and uses a wheelchair. (R3) was given pain medication". V18 was asked if x-ray was ordered STAT (immediately). V18 responded that she did ask the doctor to do the x-ray in the morning since it was late, but that it should be done in the morning since the resident was in pain. Surveyor asked if it was reasonable for the injury to have occurred on 9/22 but the resident not sent out to the hospital until 9/24. V18 said she only works weekends and doesn't know when the resident was finally x-rayed or sent out but that it is not practical to wait two days to get the x-ray and send the resident to the hospital. V18 stated, "If the resident complains of pain and x-rays are not done yet, we can call the doctor and get the resident sent to the hospital." Interview with V2 (Nurse Manager) on 9/29/23 at 3:45 PM, V2 stated, "Normally, if residents have symptoms, we will let the doctor know what is going on so they can order the x-ray STAT. If there is pain and swelling upon assessment, we usually get a STAT x-ray. Otherwise, I think it's two days to get the x-ray".	S9999		

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S9999	Continued From page 7 Interview with V1 (Director of Nursing) on 9/30/23 at 2:40PM, V1 stated, "My expectation is that a STAT x-ray should be done at least within four hours but (x-ray company that facility uses) has told us that their time frame for a STAT x-ray is 12 hours. I will call them first thing Monday morning and let them know that it is unacceptable. I will have to continue to educate my nurses and let them know that if a fracture is suspected that they cannot wait over four hours and will have to call the doctor back and request for the resident to be sent to the hospital. I'm not sure what the policy is but it is my expectation that the nurses would call the doctor and send the resident to the hospital if they need an x-ray. I will discuss this with Corporate as well". Interview with V16 (Medical Director) on 10/01/23 at 3:37PM, V16 stated he has not been made aware of any issues with the facility obtaining x-rays for residents and that he regularly attends quality assurance meetings with the facility. V16 added that since COVID there have been more delays, maybe because of lack of staff or something. Regarding x-rays, V16 said, "In this setting I understand that we have to wait for someone to get to the facility and such, but I would expect it (STAT x-ray) to be done within about two to three hours. If the patient is having symptoms like pain and there is an obvious fall, we can send them to the ER if we think or know that there will be a delay in getting the x-ray. If the person is in extreme pain, then we would not wait and just send them to the ER. If this is a problem that is happening, then I will follow up with the Director of Nursing personally because this shouldn't be happening". Facility provided contract from x-ray company, which did not have any indication of the expected	S9999		

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S9999	Continued From page 8 time frame for services. Facility provided policies: Fall Policy dated 07/2023 reads: Policy Statement/Overview The purposes of this procedure is to provide guidelines for evaluation of a resident in the event a fall occurred and to assist associates in identification of potential causes of the fall. Policy Detail 1. The Faber Fall Risk Assessment form (or similar fall risk evaluation) should be utilized to complete the evaluation of the residents' potential for falls during the admission process. The Faber Fall Risk Assessment form (or similar fall risk evaluation) should be completed quarterly, with significant change MDS Assessment and after every fall. 2. If a resident sustains a fall or is found on the floor without a witness to the event, associates shall evaluate for possible injuries and provide first aid or treatment as indicated. Direct care associates shall evaluate the area where the fall occurred for possible contributors. A Licensed Nurse shall notify the resident's Attending Physician and Resident Representative of the event. The Licensed Nurse shall document the fall in the resident's clinical record. The documentation of the identified interventions should be maintained in the resident clinical record and available to the direct care associates. A Licensed Nurse shall observe clinical status for 72 hours after an observed or suspected fall, and document findings in the resident clinical record. The falls should be reviewed at the Daily Stand - up Meeting following the fall for identification of any additional individualized interventions to reduce the risk of falls. An incident report shall be completed for resident	S9999		

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S9999	Continued From page 9 falls by a Licensed Nurse after the fall occurs. (A) Statement of Licensure Violations (2 of 2): 300.610a) 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. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review	S9999		

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S9999	Continued From page 10 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 requirements were not met as evidenced by: Based on interview and record review, the facility failed to follow residents' plan of care by not monitoring a resident (R1) at all times and keeping the resident free from injury; and failed to conduct a proper resident transfer by utilizing only one staff member for a resident (R3) assessed to require two staff members for transfers. These failures applied to two (R1, R3) of three residents reviewed for resident injury and resulted in R1 having an unwitnessed fall in room and obtaining a left wrist fracture and R3 obtaining a right ankle fracture during improper transfer. Findings include: 1. R1 was admitted to the facility with diagnoses that include: cerebral infarction, heart failure, Parkinson's disease, difficulty in walking, and need for assistance. R1 is no longer in the facility and expired on	S9999		

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S9999	Continued From page 11 9/15/23. R1's current care plan documents the following: Problem Onset: 5/20/22 - (R1) is at risk for falls due to decreased safety awareness, decreased strength and endurance, decreased mobility, impaired balance, unsteady gait, h/o CAD, HTN, CHF, DM, dyspepsia, hypocalcemia, carotid stenosis with hx of carotid endarterectomy, anemia, a-fib, GI bleed, CVA, Parkinson's, arthritis, thyroidectomy, s/p hosp for non-radiating left chest pain at rest, associated SOB Approaches include: Orient resident/significant other to environment and how to call for assistance, keep equipment within reach (i.e., call bell, phone, urinal, etc.), and educate resident and family regarding safety issues and risks for falls. Other care plan interventions include: assign staff to account for resident whereabouts at all times. On 8/13/23, R1 had a fall in the facility in her room. Facility submitted final incident report that reads: "On 08/13/23 around 5:45 pm, the roommate of the resident (R1) alerted the nurse on duty (NOD) that (R1) was found on the floor. The NOD immediately rushed to the room and noted (R1) sitting on the floor in her room against the wall with her hands embracing her body. The NOD immediately performed a head-to-toe assessment and noted some swelling to her left wrist. (R1) agreed to having pain to her left wrist when palpated. No bruises or skin tears noted on the exam. First aid was provided and (R1) was transferred to her bed with 1 person assistance. (R1) was made comfortable, fall precautions maintained and care plan updated. MD notified with orders to send (R1) to the ER. Daughter made aware. (R1) was transferred to (local) hospital ER via ambulance transfer on 08/13/23	S9999		

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at 5:55pm. (R1) was discharged from the ER on 08/14/23 and was admitted back to the facility at around 9am on 08/14/23 with a diagnosis of left wrist closed fracture. (R1) has a posterior mold applied to her left wrist. Facility immediately started an investigation. Conclusion: Based on the investigation, chart review and staff interviews, it was determined that the fracture had resulted from the fall. Care plan was updated with new fall interventions in place. All staff were educated on fall prevention."

The NOD on 08/13/23 was V10 (RN). (V10) was interviewed and per (V10), (R1's) son visited R1 on 08/13/23 around 4pm, left (R1) in her bedroom alone in a wheelchair and left the building without informing any staff. The last time (V10) saw (R1) prior to the incident was when R1 was with her son and (V10) thought (R1) was with her son.

Incident witness statement dated 8/13/23, written by V10 (RN), reads: "When I am passing the medication in the hallways, one of my residents called me to her room. When I went to her room, the resident was on the floor in a sitting position. Leg extended and her hand braced her body. I called other nurse to put her in the bed. Head to assessment done. Noticed left hand wrist swelling. Informed doctor. Sent to (local hospital)". [sic]

Root cause analysis for incident dated 8/13/23 at 5:45PM, completed by V10 (RN) documents, "Resident (R1) was trying to stand from wheelchair and trying to walk to her room and fell near chair and was in wheelchair; intervention most appropriate is listed as "close supervision."

9/30/23 at 9:50AM, V1 (DON) stated, "I don't

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION RESURRECTION PLACE	1001 NORTH GREENWOOD AVENUE PARK RIDGE, IL 60068

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S9999	Continued From page 13 know too much about (R1), but I do know that she was a frequent faller. We tried to keep her near the nurses station and monitor her at all times. She should have been monitored every hour; we don't document that anywhere. There are assigned CNA's when they are in the dining room to keep an eye on the residents. In this instance, it does look like she fell by trying to get up from her wheelchair. Even if we would tell her not to stand up by herself, she would do it anyway". 2. R3 was admitted to the facility with diagnoses that include: multiple sclerosis, obesity, overactive bladder, and insomnia. Per MDS dated 4/18/23 and 7/12/23, R3 requires extensive assistance, one-person physical assist. Interview with V14 (RN/Restorative) on 9/30/23 at 12:50 PM, confirmed the MDS was coded as one person assist in error. V14 provided copy of R3's care card (undated) that shows resident is two person assist for transfers and bed mobility; but since she fell, now she requires a mechanical lift. V14 added that moving forward the care cards should be dated. R3's current care plan documents the following: Problem Onset: 04/21/2023 - (R3) requires extensive assist with ADL's, due to decreased strength and endurance, decreased balance, decreased mobility, unsteady gait, h/o overactive bladder, insomnia, MS, mood disorder, T12 and L3, compression fx, resident transferred to ARP from another SNF due to onset of progressive weakness secondary to MS. Approaches include: 5-7-23, 2 staff members to assist with transfers, and 5-19-23 educate patient 'to call, don't fall' (sign on the wall), and toilet patient before and after meal; offer to use toilet before going to bed.	S9999		

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S9999	Continued From page 14 On 9/24/23, R3 had a fall in the facility in her room bathroom. Facility submitted final incident report that reads: "(R3) complained of right ankle pain and swelling on 09/22/23. MD was notified with orders for an X-ray of the right ankle. The X-ray was taken on 09/23/23 and the results were received on 09/24/23 which showed acute displaced trimalleolar fractures with ankle malalignment. MD was notified of X Ray results. MD gave orders to send (R3) to (local hospital) ER and the resident got admitted at the (hospital) on 09/24/23 with right trimalleolar fracture. Family was notified. The facility immediately started an investigation". Investigation: (R3) is alert and oriented X4. (R3) has multiple sclerosis and has right lower extremity weakness. As a part of the investigation, we conducted staff interviews and chart review. The CNA (V15) who took care of the resident on 09/22/23 was interviewed. Per (V15), the resident asked her to help her with changing and preparing her for bedtime around 8pm. (R3) indicated that she would like to use the restroom prior to going to her bed. (V15) assisted (R3) to transfer her to the toilet. After (R3) used the toilet, she informed (V15) that she was finished. (V15) assisted (R3) to get up from the toilet with (R3) holding on to the railing. (R3) informed (V15) that she was feeling fatigued and was not able to continue standing and needed to sit down. (V15) offered (R3) assistance to transfer her to the wheelchair that was placed next to her but (R3) remained immobile and verbalized her concerns of falling. (V15) immediately lowered (R3) to the floor in a sitting position and called for assistance. With the assistance of another CNA, (V15) safely transferred (R3) to the wheelchair and returned her back to her bed. (V15) immediately notified the nurse on duty (NOD) about what had	S9999		

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S9999	Continued From page 15	S9999		

happened. The NOD completed an assessment and (R3) complained of having right ankle pain and swelling. Upon interview, (R3) told the NOD "I did not fall but I may have twisted my ankle when I moved, I am not sure". The NOD immediately provided first aid to (R3) and notified the MD. The MD gave orders for an Xray of the right ankle and pain management with Tylenol. The X Ray was taken on 09/23/23 and the results were received on 09/24/23 which showed acute displaced trimalleolar fracture with ankle misalignment. The MD was notified of X Ray results with orders to send (R3) to (local hospital) for further evaluation and treatment. Family was notified. (R3) got admitted at local hospital on 09/24/23 and had a right ankle open reduction and internal Fixation (ORIF) done on 09/25/23. (R3) returned back to the facility on 09/26/23 with orders for non-weight bearing to the right foot. (R3) will follow up with MD (ortho surgeon) in 2 weeks on 10/10/23. Conclusion: Based on the investigation, it was noted that (R3) was eased to the floor while she was assisted during transferring from the toilet to the wheelchair. During the process of transfer, she may have twisted her ankle which may have resulted in the right ankle fracture. The facility couldn't substantiate any form of abuse or neglect."

Incident witness statement dated 9/22/23 written by V18 (RN) documented, V18 did not witness fall but that around 9:30PM CNA approached her that resident was complaining of right ankle pain. V18 documented, resident (R3) complained of pain to touch (ankle). Per CNA, resident was lowered to the floor during transfer because she was heavy, then CNA had to call for help.

Incident witness statement dated 9/26/23, written by V15 (CNA) reads:

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S9999	Continued From page 16 "On Friday, September 22, 2023, during my 3-11 shift at Ascension Living Resurrection Place, I provided care to (R3) at approximately 8 PM. (R3) expressed her desire to retire to her room for the night. Consequently, I accompanied her to her room to assist with changing and preparing her for bedtime. Upon arriving in her room, (R3) indicated that she needed to use the restroom. In response to my inquiry, she affirmed her ability to stand for a brief period. I proceeded to assist her in transferring to the toilet, which involved helping her stand, lowering her pants, and seating her on the toilet. She spent approximately 2 minutes on the toilet before informing me that she was finished. I assisted her once again in rising from the toilet, providing support as she held onto the railing. It was at this point that (R3) expressed fatigue and an inability to continue standing, stating that she needed to sit down. In response, I suggested that we turn her toward her wheelchair so she could sit on it, reassuring her that I was holding her securely. However, (R3) remained immobile, reiterating her inability to support herself and her fear of falling. Despite my efforts, I was unable to lift her due to her weight. In light of the situation, I suggested that she sit on the restroom floor while I sought assistance from another CNA to aid in her return to the wheelchair. After carefully placing (R3) on the restroom floor, I promptly summoned the assistance of another CNA to facilitate her safe transfer back into the wheelchair. Once (R3) was comfortably seated in her wheelchair, I assisted her in returning to her bed. Before leaving her room, I inquired about her well-being, to which she responded in the affirmative. Subsequently, I provided her with the call light in the case she may require any further assistance. I subsequently reported the incident to the nurse responsible for the wing, who acknowledged the	S9999		

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S9999	Continued From page 17 information. A few minutes later, (R3) utilized her call light to request assistance with her foot, which she stated was hurting. I inquired about the cause of the discomfort, and she mentioned that she believed she had twisted it. I promptly informed the nurse, who conducted an examination to assess (R3's) condition". [sic] Nursing Progress Notes document the following: 9/23/2023 12:47 AM LATE ENTRY 9/22/23 9:30 PM Resident lying in bed complained of pain on right ankle. Resident states she might have twisted her ankle. No bruise, or redness, swelling is more than the left ankle. Doctor was paged with order to do x-ray of the right ankle. And Tylenol 650 mg po every 6 hours as needed for pain. 9/23/2023 7:28 AM 11PM- 7AM shift late entry: Patient noted with swelling and tenderness on the right ankle. She verbalized that it is painful when she moves it. No redness, skin intact. Pain/discomfort is alleviated with rest and keeping her leg still. x-ray of right ankle scheduled to be done today. Endorsed to oncoming nurse. 9/24/2023 11:29 AM 1025AM: Followed-up with (x-ray company rep) for right ankle x-ray result. 1040AM: Right ankle X-ray result received with impression acute, displaced trimalleolar fractures with ankle malalignment. Orthopedic consultation is recommended. Relayed to Doctor with order to send to (local hospital) ED for further evaluation and treatment. 10:42AM: Informed resident and she is amenable to be sent to (hospital) ED. 10:47AM: Attempted to call daughter, but phone is not accepting any calls.	S9999		

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S9999	Continued From page 18 10:48AM: Called (ambulance services) - ETA between 20-30 minutes 11:10AM: Called local hospital ED c/o (staff name) - gave report. 11:30AM: EMS 2 persons arrived to pick up resident. 11:40AM: Left the unit Addendum 9/24/23 2:16 PM On 9/29/23 at 4:11PM, V18 (RN) re-affirmed what she documented in her statement and added that the CNA (V15) transferred the resident from the toilet to the wheelchair by herself and that she couldn't do it because the patient is heavy. There should be two CNA's; R3 has MS (multiple sclerosis) and uses a wheelchair. R3 was given pain medication. Review of x-ray report for R3 dated 9/23/23 documents R3 had an acute, displaced trimalleolar fracture with ankle malalignment of the right ankle; orthopedic consult was recommended. Facility provided policies: Fall Policy dated 07/2023 reads: Policy Statement/Overview The purposes of this procedure is to provide guidelines for evaluation of a resident in the event a fall occurred and to assist associates in identification of potential causes of the fall. Policy Detail 1. The Faber Fall Risk Assessment form (or similar fall risk evaluation) should be utilized to complete the evaluation of the residents' potential for falls during the admission process. The Faber Fall Risk Assessment form (or similar fall risk evaluation) should be completed quarterly, with significant change MDS Assessment and after every fall.	S9999		

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S9999	Continued From page 19 2. If a resident sustains a fall or is found on the floor without a witness to the event, associates shall evaluate for possible injuries and provide first aid or treatment as indicated. Direct care associates shall evaluate the area where the fall occurred for possible contributors. A Licensed Nurse shall notify the resident's Attending Physician and Resident Representative of the event. The Licensed Nurse shall document the fall in the resident's clinical record. The documentation of the identified interventions should be maintained in the resident clinical record and available to the direct care associates. A Licensed Nurse shall observe clinical status for 72 hours after an observed or suspected fall, and document findings in the resident clinical record. The falls should be reviewed at the Daily Stand - up Meeting following the fall for identification of any additional individualized interventions to reduce the risk of falls. An incident report shall be completed for resident falls by a Licensed Nurse after the fall occurs. Falls Prevention dated 07/2023 reads: Policy Statement The intent of this policy is to provide an environment that is free from accident hazards, over which there is control, and provide supervision and intervention to residents to prevent avoidable accidents. 1. Fall Risk Evaluation Residents shall be evaluated by a licensed nurse during the admission process, routinely and as indicated; to identify potential risk of fall. If the resident scores a higher risk for falls, the resident shall be placed on the Falling Star Program. II. Fall Risk Intervention the Interdisciplinary Team shall identify individualized interventions to reduce the risk of falls. If a systematic evaluation of a	S9999		

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S9999	Continued From page 20 resident's fall risk identifies several possible interventions, the associates may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once). 1. Falling Star Program Residents identified as members of the Falling Star Program shall have: a. A star placed next to the nameplate outside the resident room. b. The documentation of the identified interventions should be maintained in the resident clinical record and available to the direct care associates. c. If falling recurs despite initial interventions, associate shall implement additional, different interventions, or indicate reason the current approach remains relevant. This documentation should be maintained in the clinical record. 2. Graduation from the Falling StarProgram a. The interdisciplinary team may identify residents who previously scored at a higher fall risk to consider if there is a benefit of maintaining the resident on the Falling Star Program. To be considered for graduation: 1. The resident should not have a fall within 6 months of the evaluation or no change in Psychotropic Medications in past 90 days or no orthostatic hypotension within 6 months of evaluation. it. Previous indicators identified as High Risk for a fall may be resolved or identified interventions are effective. b. Interdisciplinary Team shall review residents current status and determine whether graduation from program is indicated c. Interdisciplinary Team shall review care plan interventions to be maintained post-graduation. No Violation	S9999		