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S 000	Initial Comments Annual licensure and certification survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)2)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b)The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological	S9999	**Attachment A** **Statement of Licensure Violations**	

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well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

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

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.

Section 300.1220 Supervision of Nursing Services

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

2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders,

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and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Facility failures resulted in four deficient practices:

A. Based on observation, interview, and record review the facility failed to assess side rails for entrapment risk prior to use for one of six residents (R11) reviewed for side rails in the sample of 29. This failure resulted in R11's head becoming entrapped between the side rail and the mattress. The facility continues to use the same unsafe side rail despite R11's previous entrapment and subsequent fall from the bed.

Findings Include:

The facility policy, Restraint Free, review date of

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12/20/16 documents, "Prior to the use of any side rails, a bed mobility assessment must be conducted by a therapist or licensed nurse. The resident must be able to demonstrate that they are capable of using them for bed mobility. If side rails are utilized, they must be fitted appropriately to the bed."

R11's Nurse's Notes, dated 3/16/17 at 4:15 A.M. document, "Res (resident) (R11) found saying, 'Help Me!' in bedroom. (R11) found with knees on floor wrapped in blanket and with head wedged between side rail and mattress. (R11) states (R11) needed to use the restroom. (R11) assisted up, redness noted to left ear. ROM (Range Of Motion) WNL (within normal limits). Neuros (neurological checks) started. No other injuries noted." These same Nurse's Notes document at 4:20 A.M., "Intervention: bed sensor pad for safety."

R11's admission sheet documents R11's date of admission to the facility as 08/01/15. Physician Order Sheet, dated May 2017 includes the following diagnoses: Behavioral or Psychological Symptoms of Dementia, Mood Disorder, Alzheimer's Disease and Unspecified Dementia.

R11's Minimum Data Set (MDS) Assessment, dated 3/7/17 documents R11's Cognitive Status as "Severely Impaired". This same assessment documents R11's Balance During Transitions, Surface To Surface Transfer (transfer between bed and chair or wheelchair) as a "0" (steady at all times).

R11's current Care Plan, dated 6/4/2017 documents, "Focus: (R11) is at risk for falls related to confusion, medication use. (R11) is independent with bed mobility and ambulation

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S9999	Continued From page 4 with supervision." R11's most recent quarterly Side Rail Assessment, dated 6/7/17 documents, "R11 (has) an alteration in safety awareness due to cognitive decline. And (Has) a history of falls." This same document does not address entrapment risk or appropriate alternatives attempted. On 6/7/17 at 9:58 A.M., in regards to the 3-16-17 incident, E3/Restorative Nurse stated, "(R11) was yelling, ' I have to go to the bathroom!' and 'Help Me!' E4/Licensed Practical Nurse found (R11) with (R11)'s head wedged between the side rail and the mattress. (R11) has two 1/2 rails due to altered safety awareness, a history of falls and difficulty with balance. We do not have an assessment that describes other alternatives tried before the use of the side rails. E2/Director of Nurses further stated on 6/7/17 at 12:45 P.M., "Our side rail assessments do not include risks for side rail entrapment. Our side rails are alittle out-dated." On 6/7/17 at 12:40 P.M., with E5/ Maintenance Director present, R11's bed had a mattress with two, loose, oblong half rails attached to both sides of R11's bed. These same side rails had two bars positioned vertically with an opening in the middle. When the rails were raised to the up position, they extended approximately 18 inches above the mattress. There was a gap between the mattress and the bed rail that was 3-4 inches between the mattress and the bottom of the side rail, and increased to 7 inches at the top of the side rail. Both the left and the right rail were loose and wiggled with slight movement. This wiggling increased the space to seven inches at the top of the side rails.	S9999		

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On 6/7/17 at 12:25 P.M., while in R11's room, assessing R11's bed frame, mattress and side rails, E2/Director of Nurses stated, "There is a potential for (R11)'s head to get caught in that gap (between the mattress and bed rail). Those are the same bed rails that were there when (R11) got (R11)'s head caught." E20/ Licensed Practical Nurse confirmed these same side rails have been on R11's bed since February 2017.

On 6/7/17 at 2:45 P.M., E4/Licensed Practical Nurse stated, " (On 3/16/17) I was at the med (medication) cart at the nurse's station and I heard (R11) yell, 'Help Me!' (R11) had (R11)'s head and left arm stuck between the bed rail and the mattress. The rails were kind of loose. (R11) was stuck. (R11) was unable to move. I called for another CNA (Certified Nursing Assistant) and the two of us were able to release (R11)'s hand and (R11)'s head popped out. The side rails are the same ones on (R11)'s bed now. They are large, oblong ones that are very wiggly."

R11's Nurse's Notes document on 5/14/17, "(R11) found sitting on floor next to bed with back resting against side of bed. Right leg extended out with left knee bent and sheet noted wrapped around left ankle and foot. (R11) states, 'I slid right down the bed.'

On 6/7/17 at 7:55 P.M., R11 was lying in bed sleeping. Two 1/2 side rails were in the up position. An approximate seven inch width gap was present between the mattress and the side rail. On 06/08/17 R11 was unable to remember the entrapment incident.

B. Based on observation, interview, and record review the facility failed to assess for entrapment,

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obtain informed consent and document alternatives tried before the initiation of side rails for 23 of 29 residents, R3,R7, R8, R9, R10, R11, R13, R15, R19, R20, R21, R23, R24, R25, R26, R27, R29, R31, R33, R34, R35, R36 and R57, reviewed for side rails in the sample of 29.

1.) On 6/7/2017 at 10:00AM R7's bed had bilateral horizontal quarter size bed rails with two metal vertical rods inside the rail on both left and right side of the bed. The siderails were in the upper position.
R7's Side Rail Assessment, dated 4/27/2017, documents that R7 is currently using the side rails for positioning and support, and that siderails are indicated and serve as an enabler to promote independence. R7's siderail assessment has no documentation of assessing for the risk for entrapment. There is no documentation that any interventions were attempted prior to the initiation of R7's siderails. The current medical record did not contain an informed consent for the use of the siderails.

On 6/7/2017 at 11:00AM E2/DON (Director of Nurses) stated, " We have not done any consents for the use of the siderails, and I don't see any interventions done prior to using the siderails for this resident (R7)."

2. On 6/7/2017 at 3:00PM R33's bed had bilateral vertical mini siderails on the left and right side of the bed. Both siderails were up and in place, and the right siderail had the call light monitor in the middle of the rail.

R33's Side Rail Assessment, dated 6/7/2017, documents that R33 is currently using the siderails for positioning and support. This same

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assessment documents that siderails are indicated to provide safety and serve as an enabler to promote independence. R33's siderail assessment has no documentation of assessing for the risk for entrapment. There is no documentation to show that any interventions were attempted prior to the initiation of R33's siderails. R33's current medical record did not contain an informed consent for the use of the siderail.

3.) On 6/7/2017 at 10:15AM R29's bed had bilateral one half horizontal siderails to the left and right side of bed. The siderails were in the upper position. R29's siderails have three metal vertical rods on the inside of both rails.

R29's Side Rail Assessment, dated 4/27/2017, documents that R29 is currently using the siderails for positioning and support, and that siderails are indicated and serve as an enabler to promote independence. R29's siderail assessment has no documentation of assessing for the risk for entrapment. There is no documentation to show that any interventions were attempted prior to the initiation of R29's siderails. R29's current medical record did not contain an informed consent for the use of the siderail.

4. On 6/8/2017 at 12:35PM R57's bed had bilateral horizontal one half siderails to the left and the right side of R57's bed. Both siderails were in the upper position and R57's call light was wrapped around the left siderail.

R57's Side Rail Assessment, dated 4/22/2017, documents that R57 is currently using the siderails for positioning and support, and that the siderails are indicated to provide safety. This same assessment documents that siderails are

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indicated and serve as an enabler to promote independence. R57's siderail assessment has no documentation of assessing for the risk of entrapment. There is no documentation to show that any interventions were attempted prior to the initiation of R57's
siderail. R57's medical record did not contain an informed consent for the use of the siderail.

5. R11's Minimum Data Set (MDS) Assessment, dated 3/7/17 documents R11's Cognitive Status as "Severely Impaired". This same assessment documents R11's Balance During Transitions, Surface To Surface Transfer (transfer between bed and chair or wheelchair) as a "0" (steady at all times).

R11's current Care Plan, dated 6/4/2017 documents, "Focus: (R11) is at risk for falls related to confusion, medication use. (R11) is independent with bed mobility and ambulation with supervision."

R11's most recent quarterly Side Rail Assessment, dated 6/7/17 documents, "R11 (has) an alteration in safety awareness due to cognitive decline, and (has) a history of falls." This same document does not address entrapment risk or appropriate alternatives attempted.
R11's current medical record did not contain an informed consent for the use of the side rails nor any documentation of alternatives tried before the initiation of the side rails.

On 6/7/17 at 12:40 P.M., with E5/ Maintenance Director present, R11's bed had a mattress with two, loose, oblong half rails attached to both sides of R11's bed. These same side rails have two bars positioned vertically with an opening in the middle. When the rails are raised to the up

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position, they extend approximately 18 inches above the mattress. There is a gap between the mattress and the bed rail that is 3-4 inches between the mattress and the bottom of the side rail, and increases to 7 inches at the top of the side rail. Both the left and the right rail are loose and wiggle with slight movement. This wiggling increases the space to seven inches at the top of the side rails.

6. R20's current Minimum Data Set, dated 5/8/17 documents R20's bed mobility as, "Limited Assistance" and balance during surface-to-surface transfers as "Not steady, but able to stabilize without staff assistance."

R20's current Care Plan, dated 5/9/17 documents, "Focus: (R20) is at risk for falls related to an actual fall on 12/30/16. (R20) is stand-by-assist for transfers."

R20's most recent, quarterly Side Rail Assessment, dated 5/5/17 documents, "(R20) has an alteration in safety awareness due to cognitive decline. And (has) a history of falls." This same document does not address entrapment risk or appropriate alternatives attempted.

R20's current medical record did not contain an informed consent for the use of the side rails nor any documentation of alternatives tried before the initiation of the side rails.

On 6/7/17 at 10:30 A.M., R20's bed had a 1/2 side rail present to each side of the bed. These rails extended from the head of the bed to the middle of the middle of the bed. When the rails are raised to the up position, there were two

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vertical bars positioned with a seven inch gap between them.

7. R24's current Minimum Data Set, dated 5/1/17 documents R24's bed mobility as, "Limited Assistance" and balance during surface-to-surface transfers as "Steady at all times."

R24's current Care Plan, dated 5/2/17 documents, "Focus: (R24) is a fall risk and is impulsive and will attempt to stand and transfer self."

R24's most recent, quarterly Side Rail Assessment, dated 5/3/17 documents, "(R24) has an alteration in safety awareness due to cognitive decline. And (has) a history of falls." This same document does not address entrapment risk or appropriate alternatives attempted.

R24's current medical record did not contain an informed consent for the use of the side rails nor any documentation of alternatives tried before the initiation of the side rails.

On 6/7/17 at 11:00 A.M., R24's bed had a 1/2 side rail present to each side of the bed. These rails extended from the head of the bed to the middle of the middle of the bed. When the rails are raised to the up position, there were two vertical bars positioned with a seven inch gap between them.

8. R35's current Minimum Data Set, dated 3/4/17 documents R35's bed mobility as, "Limited Assistance" and balance during surface-to-surface transfers as "Steady at all times."

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R35's current Care Plan, dated 2/6/17 documents, "Focus: (R35) is at risk for falls related to an actual fall on 2/6/17 and 2/8/17. (R35) is independent for transfers."

R35's most recent, quarterly Side Rail Assessment, dated 6/7/17 documents, "(R35) has an alteration in safety awareness due to cognitive decline. And (has) a history of falls." This same document does not address entrapment risk or appropriate alternatives attempted.

R35's current medical record did not contain an informed consent for the use of the side rails nor any documentation of alternatives tried before the initiation of the side rails.

On 6/7/17 at 11:30 A.M., R35's bed had a 1/2 side rail present to each side of the bed. These rails extended from the head of the bed to the middle of the bed. When the rails are raised to the up position, there were two vertical bars positioned with a seven inch gap between them. 9. R25's Side rail assessment, dated 6/6/17, documents that R25 has alterations in safety awareness due to cognitive decline. R25's side rail assessment has no documentation of assessing for R25's risk of entrapment, nor of any interventions were attempted prior to the initiation of the side rails.

R25's care plan, dated 3/14/17, has no documentation addressing the use of R25's bilateral half side rails.

R25's Physician's orders, dated 5/2017, documents that R25 has the diagnoses of Insomnia, Mood disorder, and Dementia with

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behaviors.

R25's Behavior Monitoring Record, dated 5/2017, documents that R25 has a history of behaviors of verbally abusing, refusing cares, Insomnia, and Depression.

On 6/6/17 at 9:30 a.m., R25 was lying in bed with bilateral half side rails up. E9 (Registered Nurse) directed R25 to grab R25's right side rail to assist with turning during wound care. R25 was able to grab the side rail and with the assist of one turned to R25's right side. R25's side rails had six vertical bars and four horizontal bars with multiple openings large enough for an extremity to go through.

10. R26's Side rail assessment, dated 6/8/17, documents that R26 is comatose, semi-comatose, obtunded, or has fluctuations in level of consciousness, and has alterations in safety awareness due to cognitive decline. R26's side rail assessment has no documentation of assessing for R26's risk of entrapment, nor of any interventions were attempted prior to the initiation of the side rails.

R26's Physician's orders, dated 5/2017, documents that R26 has the diagnoses of Parkinson's disease, Anxiety, and Dementia.

R26's Fall risk assessment, dated 5/24/17, documents that R26 scored a twelve putting R26 at a high risk for falls.

R26's Care plan, dated 6/2/17, documents that R26 has impaired cognition function and impaired thought processes. The care plan also has no documentation addressing R26's use of R26's bilateral half side rails.

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On 6/5/17 at 11:40 a.m., R26 was lying in bed with bilateral half side rails up. E18 (Registered Nurse) directed R26 for R26 to grab onto the left side rail to assist with turning. R26 was able to grab onto the side rail and turn to R26's left side with the assist of one. R26's bilateral half side rails had four vertical bars and four horizontal bars with openings large enough for an extremity.

11. R31's Side rail assessment, dated 4/28/17, documents that R31 receives medications which would require increased safety precautions. R31's side rail assessment has no documentation of assessing for R26's risk of entrapment, nor of any interventions were attempted prior to the initiation of the side rails.

R31's Physician's orders, dated 5/2017, documents that R31 has a diagnosis of a right femur fracture related to falls.

R31's Care plan, dated 5/5/17, has no documentation addressing the use of R31's bilateral half side rails.

On 6/8/17 at 11:00 a.m., R31 was lying in R31's bed with bilateral half rails up. R31 turned herself to her left side using the side rail on R31's left side. R31's half side rails were rectangular shaped with two vertical bars and one horizontal bar with openings large enough for an extremity.

12. On 6/7/17 at 12:55 p.m., R8 was lying in R8's bed with R8's bilateral half rails up. R8 was demonstrating uncontrollable tremors to R8's bilateral hands. E19 (Licensed Practical Nurse) directed R8 to grab R8's right side rail to assist with turning. R8 grabbed the right side rail with R8's left hand and with minimal assistance was

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S9999	Continued From page 14 able to turn R8 to his right side. R8's Brief Interview Mental Status, dated 2/6/17, documents that R8 had a score of five signifying that R8 has severe cognitive impairment. R8's Care plan, dated 2/13/17, has no documentation addressing the use of R8's side rails. R8's side rail assessment, dated 4/7/17, documents that R8 is comatose, semi-comatose, obtunded, or has fluctuations in level of consciousness, and has alterations in safety awareness due to cognitive decline. R8's side rail assessment has no documentation of assessing for R8's risk of entrapment, nor of any interventions were attempted prior to the initiation of the side rails. R8's Fall risk assessment, dated 4/7/17, documents that R8 has a score of 14 signifying that R8 is at a high risk for falls. R8's Physician's orders, dated 5/2017, document that R8 has the diagnoses of Parkinson's disease and Lewy Body Dementia. R8's Behavior Monitoring Record, dated 5/2017, documents that R8 has a history of delusions. 13. On 6/5/17 at 9:45a.m., there was a metal oblong, 3/4-length side rail attached to the upper portion of R9's bed on the left side, against the wall. This side rail had a horizontal division bar between the top and bottom of the side rail, leaving an approximate 3 inch open space above and below the bar. On the right side of R9's bed was a rectangular, half-length white metal side	S9999		

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rail, approximately 20 inches wide and 12 inches high. This rail had no division bars, leaving an open area of approximately 18 inches wide by 12 inches high.

R9's Side Rail Assessment, dated 4/30/17, does not include an assessment for entrapment risks. R9's clinical record does not include an informed consent for the use of side rails or alternatives attempted prior to the implementation of the side rails.

14. On 6/5/17 at 9:50a.m., there were bilateral, plastic, oblong, half-length padded side rails with 3 division bars each, spaced approximately 3 inches apart, attached to the upper portion of R15's bed.

R15's clinical record does not include an informed consent for the use of side rails or alternatives attempted prior to the implementation of the side rails. R15's Side Rail Assessment, dated 5/14/17, does not include assessment for entrapment risks.

15. On 6/5/17 at 1:45p.m., there were bilateral hard plastic, half-length side rails attached to each side of the upper portion of R21's bed with three division bars present on each rail, spaced approximately 3 inches apart.

R21's clinical record does not include an informed consent for the use of side rails or alternatives attempted prior to the implementation of the side rails. R21's Side Rail Assessment, dated 4/28/17, does not include assessment for entrapment risks.

16. On 6/5/17 at 1:45p.m., there were bilateral oblong, quarter-length side rails attached to the

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S9999	Continued From page 16 upper portion of R23's bed. These side rails had two division rails approximately 3 inches apart. R23's Side Rail Assessment, dated 6/7/17, does not include assessment for entrapment risks. R23's clinical record does not include informed consent for the use of side rails or alternatives attempted prior to the implementation of the side rails. 17. On 6/7/17 at 12:20 PM, R10's bed contained 2 oblong 1/2 side rails on both sides of the bed with 2 horizontal bars which created a 6-7 inch gap in the middle of the 2 bars. R10's current medical record does not include an informed consent, nor documentation of alternatives attempted prior to the initiation of the side rails. R10's Side Rail Assessment dated 4/23/17 does not document an assessment for entrapment risk. 20. On 6/7/17 at 1:00 PM, R19's bed contained two oblong upper half side rails in the up position with five vertical bars creating gaps measuring approximately seven inches in width from bar to bar across the side rails. R19's current medical record does not include an informed consent, nor documentation of alternatives attempted prior to the initiation of R19's side rails. R19's Side Rail Assessment dated 4/29/17 does not document an assessment for entrapment risk. 21. On 6/7/17 at 11:30 AM, R27's low bed contained two upper bed mobility assist grab bar side rails in the up position that measure	S9999		

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S9999	Continued From page 17 approximately six inches wide. R27's current medical record does not include an informed consent, nor documentation of alternatives attempted prior to the initiation of R27's side rails. R27's Side Rail Assessment dated 4/27/17 does not document an assessment for entrapment risk. 22. On 6/7/17 at 12:45 PM, R34's bed contained two oblong upper half side rails in the up position with five vertical bars creating gaps measuring approximately seven inches in width from bar to bar across the side rails. 20. On 6/7/17 at 1:00 PM, R19's bed contained two oblong upper half side rails in the up position with five vertical bars creating gaps measuring approximately seven inches in width from bar to bar across the side rails. R19's current medical record does not include an informed consent, nor documentation of alternatives attempted prior to the initiation of R19's side rails. R19's Side Rail Assessment dated 4/29/17 does not document an assessment for entrapment risk. 21. On 6/7/17 at 11:30 AM, R27's low bed contained two upper bed mobility assist grab bar side rails in the up position that measure approximately six inches wide. R27's current medical record does not include an informed consent, nor documentation of alternatives attempted prior to the initiation of R27's side rails.	S9999		

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S9999	Continued From page 18 R27's Side Rail Assessment dated 4/27/17 does not document an assessment for entrapment risk. . 22. On 6/7/17 at 12:45 PM, R34's bed contained two oblong upper half side rails in the up position with five vertical bars creating gaps measuring approximately seven inches in width from bar to bar across the side rails. R34's current medical record does not include an informed consent, nor documentation of alternatives attempted prior to the initiation of R34's side rails. R34's Side Rail Assessment dated 5/21/17 does not document an assessment for entrapment risk. 23. On 6/7/17 at 12:56 PM, R3 was lying in bed. R3's bed contained two rectangular upper half side rails in the up position with one horizontal bar creating two gaps measuring approximately four inches in width from bar to bar across the side rails. R3's current medical record does not include an informed consent, nor documentation of alternatives attempted prior to the initiation of R3's side rails. R3's Side Rail Assessment dated 4/29/17 does not document an assessment for entrapment risk. On 6/7/17 at 12:10 PM, E2, Director of Nursing, stated that the facility does not obtain informed consents for any resident at the facility prior to the initiation of side rails. At this same time, E2 stated the facility does not document alternatives tried prior to the initiation of side rails for any resident at the facility. E2 stated, "I know alternatives are a problem. It's a widespread problem. Our side rails are a little outdated." E2 then verified that	S9999		

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S9999	Continued From page 19 the facility's current Side Rail Assessments do not assess for entrapment risk. (A) 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b)The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		

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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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

Based on interview and record review, the facility failed to document, assess and investigate an incident and failed to implement new fall interventions after each fall for three of 13 residents (R10, R13 and R27) reviewed for falls in a sample of 29. These failures resulted in R13 falling and requiring transfer to a local hospital for,"associated head injury, facial swelling and purple skin color changes." These failures also resulted in R27 falling and sustaining a forehead laceration and subsequently requiring transport to a local hospital for placement of sutures to repair the laceration.

The facility's Event Management policy (revised 12/20/16) documents the following: "An important component of a Quality Assurance and

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Assessment Plan is an effective Event Management system. Event Management includes a daily review of all events by the DON (Director of Nursing) or designee. Ideally, all events are reviewed at daily meetings for timely and effective follow-up." This same policy also documents, "Procedure: The charge nurse shall initiate an Incident Report for required high-risk events. Determine if the care plan was followed as written. Based on initial assessment, immediate revision to the care plan to minimize the risk of repeat incident."

1. R13's most recent quarterly MDS (Minimum Data Set Assessment) dated 4/13/17 documents R13 has a BIMS (Brief Interview for Mental Status) of 7 of 15, is alert and confused.

R13's Fall Risk Assessments dated 6/1/16 and 3/3/17 documents R13's has fall scores rated 7 and 9, indicating R13 is not a high fall risk.

R13's fall tracking log dated 6/1/16- 6/2/17 indicates R13 fell at the facility 19 times during this time frame.

On 6/8/17, E3, Restorative Nurse was unable to provide investigations of R13's falls on 6/2/16 and 10/12/16.

R13's Investigation form dated 6/18/16 documents R13 was found on the floor with no alarms going off. The same form documents, "Suggested Intervention: alarm when put to bed (battery)."

On 6/8/17 at 11:30 AM E3, Restorative Nurse, stated on 6/18/16, R13's alarm was not functioning properly and the intervention was to

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S9999	Continued From page 22 check the alarm batteries. R13's Investigation form documents on 6/24/16, R13 attempted to get self from wheelchair to toilet. The same form does not document an immediate intervention nor was an intervention care planned until 7/3/16. This form documents R13 sustained a skin tear to the right forearm from this fall. R13's Investigation form dated 6/25/16 documents R13 asked to go to bed at 4:55 PM and was advised by staff to wait a few minutes because the staff were passing out meals for supper and it takes 2 staff to help R13. R13 fell at 5:00 PM. This form documents the intervention was to take R13 to the "main area" for observation while staff was helping other residents with supper. R13's Event Report dated 10/11/16 at 6:50 PM, R13 was yelling out for help and was found on the bathroom floor in front of the wheelchair. This same form documented an intervention of a chair alarm. On 6/8/17 at 11:30 AM, E3, Restorative Nurse, stated E3 was not sure if a chair alarm was implemented because it was not documented in R13's care plan until 2/1/17. R13's fall tracking log documented R13 had a fall on 10/12/16. On 6/8/17 at 11:30 AM, E3, Restorative Nurse, stated there was no investigation available for R13's fall on 10/12/16. E3 stated according to the R13's care plan, E3 believes the intervention was frequent toileting. R13's Investigation form dated 10/18/16 documents R13 was found in R13's bathroom and was trying to get in the wheelchair from the	S9999		

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toilet. R13's same investigation form is blank for the section titled, "suggested interventions." On 6/8/17 at 11:30 AM, E3, Restorative Nurse, verified an intervention was not implemented for this fall.
R13's Event Report dated 11/7/16 documents R13 was found on the floor in the bathroom. This same form documents the following immediate interventions: "Chair alarm, use call light and CNA's (Certified Nursing Assistants) to attend to her quickly for bathroom requests." R13's fall intervention for a fall on 10/11/16 was also to implement a chair alarm.

R13's Event Report dated 11/21/16 documents, "(R13) asking to go to bed for 1 1/2 hours, fell in BR (bathroom)." This same form documents the following fall interventions: "Use call light, lock BR door (has alarm), has bed alarm, no body alarm on, body alarm." On 6/8/17 at 11:30 AM, E3, Restorative Nurse, stated the staff did not answer R13's call light timely on 11/21/16.

R13's Event Report form dated 11/26/16 documents that R13, "Was found on the floor out of her W/C (wheelchair), no alarm sounding." This same form documents the following immediate fall interventions: "Make sure body alarm is on, obtain a UA (Urinalysis)." On 6/8/17 at 11:30 AM, E3, Restorative Nurse, verified R13's, "Alarm was not sounding."

R13's Event Report dated 12/7/16 documents R13 was found sitting on buttocks in the bathroom. This same form did not document an immediate intervention.
R13's Event Report dated 12/10/16 documented R13, "Scooted self off low bed." The same form documents the immediate fall intervention was to implement a chair alarm.

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R13's Event Report dated 1/27/17 documents R13 was found on the floor in the bathroom and was trying to get off of the toilet. This same form documents R13, "Has raised area to top of head, ice pack applied, area non open, bruised." This form documents R13 had been asking to go to bed and was told she had to wait. This same form documents the following immediate interventions: "re-orient the need to ask for assist, re-orientate to call light use." R13's emergency room report dated 1/31/17 documents, "presented to ED (Emergency Department) for a fall occurring 3 days ago with associated head injury, facial swelling and purple skin color changes." On 6/8/17 at 11:30 AM, E3, Restorative Nurse, stated this fall was due to, "non-compliance with the bathroom door alarm." E3 verified that R13 received a Hematoma from this fall and was sent to the Emergency Department.

R13's Event Report dated 2/3/17 documents R13 was found on the floor with her wheelchair tipped over on its side and R13 was trying to get to the bathroom. This same form documents the following immediate interventions for falls: "frequent toileting, bed/body alarms already in use, do not leave alone in room unless in bed." On 6/8/17 at 11:30 AM, E3, Restorative Nurse, stated frequent toileting had already been used as an intervention for a previous fall.
R13's Event Report dated 3/1/17 documents R13 was found on the floor after attempting to self transfer. This same form documents the following immediate interventions: "Resident with behaviors, already toileted 15 minutes before the incident, put resident to bed after toileting." On 6/8/17 at 11:30 AM, E3, Restorative Nurse, stated no immediate intervention was put in place after

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this fall. E3 stated a scoop mattress and a pad for the wheelchair was not implemented until 3/7/17.

R13's Event Report dated 3/24/17 documents R13 was found sitting on floor mat next to bed. This same form documents the following immediate interventions: "replaced bolster pillows, made sure (R13) was clean, dry and calm." On 6/8/17 at 11:30 AM, E3, Restorative Nurse, stated a new and different intervention was not implemented for R13's fall on 3/24/17.

R13's Event Report dated 5/10/17 documents R13 was found lying on her right side on the bathroom floor. This same form documents the following as an immediate fall intervention: "The personal alarm string was tangled around the W/C (wheelchair) handle. Need to make sure alarm was attached to (R13) and functions properly. Also, BR (bathroom) door alarm was de-activated. Need to make sure all alarms are active." On 6/8/17 at 11:30 AM, E3, Restorative Nurse, stated R13's bathroom door alarm was not sounding when R13 fell.

2. R27's Fall Tracking Log dated 6/26/16 - 6/2/17 indicates R27 fell 16 times at the facility during this time frame.

R27's Fall Risk Assessment dated 4/27/17 documents a score of 20, indicating R27 is a high risk for falls.

R27's Fall Investigation dated 7/4/16 documents that R27 was found sitting on the floor with R27's wheelchair upside down. This same form documents the new immediate intervention to perform a bladder scan.

On 6/12/17 at 10:45 AM, E3, Restorative Nurse,

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verified that R27's bladder scan was not completed. E3 then stated that if this intervention was not completed, another intervention should have been implemented.

R27's Fall Investigation dated 7/22/16 documents that R27 was found on the floor in front of the toilet with R27's wheelchair tipped over. This same form documents the immediate intervention for a therapy referral.

On 6/12/17 at 10:45 AM, E3 stated that the intervention for R27's therapy referral was not an appropriate intervention because R27 was already on ambulation and AROM (active range of motion) programs. E3 then verified that no new fall intervention was implemented after R27's 7/22/16 fall.

R27's Fall Investigation dated 10/4/16 documents that R27 was found lying on the bathroom with R27's wheelchair tipped over. This same forms documents the immediate intervention for a medication review.

On 6/12/17 at 10:45 AM, E3 stated that E3 could not locate any documentation that a medication review was completed after R27's 10/4/16 fall. E3 then stated, "Something different should have been done."

R27's Fall Investigation dated 10/9/16 documents that R27 was found lying on the floor after attempting to use the restroom. This same form documents the immediate intervention to evaluate for the facility's locked dementia unit.

On 6/8/17 at 1:34 PM, E3 stated that R27 was evaluated for the facility's locked dementia unit, and the decision was made that R27 was not a candidate. E3 then stated that no new

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intervention was implemented after R27's 10/9/17 fall and one should have been implemented to prevent future falls.

R27's Fall Investigation dated 11/10/16 documents that R27 was found on the floor with R27's wheelchair flipped over on top of R27. This same report documents that R27 was sent to a local hospital for evaluation of a head injury and forehead laceration, and R27 received 3 sutures to repair the forehead laceration.
R27's local hospital Emergency Room report dated 11/10/16 documents that R27 was evaluated for a head injury after R27's fall on 11/10/16, and 3 sutures were placed to repair R27's forehead laceration.

R27's Fall Investigation dated 12/6/16 documents that R27 was found on the bathroom floor after attempting to self transfer. This same form does not document a new fall intervention.

On 6/8/17 at 1:34 PM, E3 verified that no fall prevention intervention was implemented after R27's 12/6/16 fall and stated, "One (fall intervention) should have been implemented."

3. R10's fall tracking log dated 1/1/17- 5/16/17 indicates R10 fell at the facility 7 times during this time frame.

R10's Event Report dated 2/14/17 documents R10 was found on the floor beside the bed, and the bed alarm did not go off. This same form does not document an immediate intervention for this fall.

R10's Event Report dated 4/4/17 documents R10 was found sitting on the floor in R10's room. This same form documents the following immediate

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fall intervention: "Offered to toilet (R10). (R10) refused. A lot of encouragement needed to toilet resident."

R10's Event Report dated 5/16/17 documents R10 tried to get up without assistance and slid to the floor from R10's recliner chair. This same form also documents, "Alarm not placed appropriately, sitting on ledge of window in (R10's) room." This same form documents the following immediate intervention for this fall: "put alarm in place."

On 6/8/17 at 11:30 AM, E3, Restorative Nurse, verified an immediate intervention was not put in place for R10's falls on 2/14/17 and 4/14/17. E3 stated R10's chair alarm was non the edge of the window and the intervention was to put it in place.

D. Based on interview and record review, the facility failed to provide supervision for a male resident with a known history of sexually inappropriate behaviors. R30 is one of twenty-six residents reviewed for supervision in a sample of 29. This failure affects two residents (R11and R30).
R30's current Physician Order Sheet, dated May 2017 documents that R30 was admitted to the facility on 5/23/16 with the following diagnoses:Unspecified Dementia Without Behavioral Disturbances, Heart Failure, Edema and Hypertension.

R30's Minimum Data Set Assessment, dated 3/4/17 documents R30 as, "Independent with Bed Mobility, Transfers and Ambulation."

R30's Nurse's Notes document on 5/29/16 at 8:00 P.M., "(R30) observed very close to (female resident) in the Day Room, attempting to kiss her

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face." On this same date at 8:30 P.M., R30's notes document, "(R30) in Sitting Room and when I turned around, (R30) was kissing (another female resident) at the table."

On 6/25/16 at 8:45 P.M., R30's Notes document, "CNAs (Certified Nursing Assistants) found (R30) behind the nurse's station standing over (female resident) that was sitting in a chair, kissing."

On 7/5/16 at 10:45 P.M., R30's Nurse's Notes document, "Very touchy with staff, trying to kiss the nurse's hand. Touching other family members. Staff has told him to move away from (female) residents multiple times. Caught trying to touch a resident multiple times, making a kissy face to her."

On 7/6/16 at (12:45 A.M.), R30's Nurse's Notes document, "(R30) sitting at table with female resident at the start of the shift.
Took (midnight) medication easily. Has been agitated and ambulating in hallway, looking into female resident's room after supervisor escorted female resident to room. (R30) states, 'Are you the police? This is not your business.' "

On 7/16/16 at 5:00 A.M., R30's Notes document, "(R30) witnessed by CNA attempting to make physical contact with a female resident in the hallway."

On 8/9/16 at 7:20 A.M., R30's Nurse's Notes document, (R30) in Day Area attempting to reach out and inappropriately touch another (female) resident."

On 8/10/16 at 12:15 P.M., R30's Notes document, "(R30) sat out in Man Dining Room most of the day. Tried to get a few lady residents

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to sit by him."

On 1/29/17 at 2:45 P.M., R30's Nurse's Notes document, "(R30) was walking out of bedroom around 11:45 A.M. (R30) opened (R30)'s door when CNAs were coming in. (R30) stated (R30) didn't know where the lady in (R30)'s room came from. (R30) was buttoning (R30)'s pants as (R30) left the room."

The facility Event Report, dated 1/29/17 documents, "Lunch carts had arrived. CNAs were looking for a female resident (R11). (R11) was found on the floor next to (R30)'s bed. (R11) had (R11)'s pants halfway down around (R11)'s buttocks. (R30) was coming out of the door as the CNAs were going in stating (R30) didn't know where (R30) came from and (R30) was crazy. (R30) was buttoning up (R30)'s pants."

On 6/6/17 at 11:50 A.M., E7/CNA stated, "It was about lunch time, I noticed (R11) wasn't in the dining room. I checked all the rooms on the hallway. I opened (R30)'s door after I knocked. (R11) was lying on the floor on (R11)'s side. (R11)'s pants were down, exposing (R11)'s buttocks. I saw (R30) zipping (R30)'s pants up."

On 6/6/17 at 12:15 P.M., E6/CNA stated, "On 1/29/17 I couldn't find (R11). I knocked on (R30)'s door and opened it. (R11) was lying on the floor, covered with a blanket. I moved the blanket and noticed (R11)'s pants were down with (R11)'s private area exposed."

On 6/6/17 at 12:45 P.M., E8/Licensed Practical Nurse stated, "(R30) was in the Day Area sitting there for awhile. When trays came, we couldn't find (R11). The CNAs went to find (R11). They called me to (R30)'s room and I saw (R11) lying

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S9999	Continued From page 31 on the floor. (R11)'s pants were down. I could see (R11)'s buttocks. I did an assessment to see if (R11) had hurt (R11)'s self. I did not check (R11) for sexual abuse. I reported it to my supervisor. I did not send (R11) to the Emergency Room to be checked." On 2/2/17 at 6;30 P.M., R30's Nurse's Notes document, "Review of camera footage from 1/29/17 shows (R30) repeatedly attempt to lure female resident into (R30)'s room. (R30) is persistent and insistent. (R30) is the instigator. Due to past and present reports from staff (R30)'s sexual intent has increased." (B)	S9999		