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S 000	Initial Comments Complaint Investigation: 2190658/IL130597	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)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 well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three	S9999		

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S9999	Continued From page 2 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: Based on observation, interview, and record review, the facility failed to follow their fall prevention program by failing to monitor residents at high risk for falls and with a history of multiple falls; failed to implement safety interventions for each resident identified at-risk for falls; failed to inform/instruct nursing staff of residents at-risk for falls to prevent serious injury; and failed to develop individualized plans of care and interventions to mitigate falls for residents assessed to be at risk for falls and with a history of falls. These failures affected five of five residents (R1, R2, R3, R4, and R5) reviewed for falls with injuries and resulted in (R1) having a fall , with injury, which resulted in a left hip fracture; (R2) having 14 falls while in the facility; (R3) having a fall that resulted in a left femur fracture; (R4) having a fall that resulted in a shoulder fracture; and (R5) having seven falls while in the facility. Findings include: 1. R1 was an 84 year old resident with diagnoses of Alzheimer's Disease, Major Depressive Disorder, Abnormalities of Gait and Mobility, Unsteadiness on feet and lack of coordination. Facility fall incident report dated 2/2/21 written by V2 (Director of Nurses), stated in part (but not	S9999		

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S9999	Continued From page 3 limited to): "Date of occurrence: 1/25/21. Time of occurrence 12:00 PM. Resident name: (R1). Diagnosis: Alzheimer's Disease, Major Depressive Disorder. Hospitalization Diagnosis: Left Hip Fracture. Final report Summary: On 1/25/21 (R1) was observed standing and attempting to ambulate. R1 lost his balance, causing him to fall on his left side. V7 (CNA) witnessed the fall, and attempted to prevent the fall, however was unable to reach him in time. R1 was sent to hospital on 1/25/21 where a left hip fracture was confirmed." Facility records show R1 fell a total of 7 times: Fall 1 on 7/1/20, R1 had un-witnessed/un-supervised fall and was found on bathroom floor in an unoccupied room. Fall 2 on 9/12/20, R1 had a witnessed fall and sustained an injury in the dining room ,due to falling on his face and then sent to the hospital ER for treatment of lacerations to his ear. Fall 3 on 9/14/20, R1 had un-witnessed/un-supervised fall in the dining room and was sent to the hospital ER for a CT scan to the head to ensure there was no bleeding in his brain. Fall 4 on 9/22/20, R1 had a witnessed fall in the dining room ,while he was walking without assistance, and fell backwards on his buttocks. Fall 5 on 9/27/20, R1 had an un-witnessed/un-supervised fall in the dining room and was found on the floor by a housekeeper. Fall 6 on 10/28/20, R1 had an un-witnessed/un-supervised fall in a vacant bedroom and was found lying on his side. R1 was sent to the hospital ER for further evaluation. Fall7 on 1/25/21, R1 had a witnessed fall in the dining room. R1 stood up from his wheelchair and fell to the ground, sent to the hospital ER and	S9999		

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S9999	Continued From page 4 diagnosed with a left hip fracture. Nursing progress notes written on 1/26/21 at 11:52 PM by V12 (RN) stated, "Called to room by CNA on duty at 10:15 PM . Noted resident without pulse, respirations, or blood pressure. No spontaneous movements were present, no response to verbal or tactile stimuli. Resident DNR (Do Not Resuscitate). Death was pronounced by writer and second RN at 10:15 PM." On 2/14/21 at 10:45 AM, Surveyor entered the second floor of the facility and spoke to V3 (Registered Nurse/RN) and was asked about R1's fall incident. V3 stated, "Yes I know about that. (R1) had a fall but he was on hospice already and he was sent out to the hospital, came back, and I heard he died. I wasn't the nurse that was on duty when he fell." Surveyor asked what type of floor R1 was on, V3 stated, "This is a dementia floor and he was oin his wheelchair, sitting right outside his room." Surveyor asked how many residents were considered high risk for falls. V3 stated, "Most everyone here is high risk for falls." Surveyor asked what fall preventative measures were implemented for R1 and for other residents on the dementia floor. V3 stated, "We try to watch them closely, we keep their call lights within reach, and we use fall mats." Tour of the dementia floor where R1 resided showed no floor mats placed with residents who were still in their beds . Call lightswere observed not within reach of residents. V3 (Registered Nurse/RN) accompanied surveyor to check resident rooms and observed almost every call light that was left on the floor or behind the bed and not within reach of residents. V3 stated, "I don't know why these call lights aren't within reach of these residents but I will let all the CNAs know."	S9999		

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Surveyor asked if she was able to see any fall mats placed beside the beds of any of the residents that were still in bed, V3 stated, "We used to use them , there should be mats on the residents that are in bed, especially if they have a history of falling out of bed." Surveyor asked what other fall preventative measures the facility used for the residents at risk for falls, V3 stated, "I know we just try to monitor everyone frequently but we don't use any kind of bed alarms or chair alarms but I will relay your concerns with management." Surveyor asked V3 if she knew of the facility fall protocols, V3 stated, "I'm not sure." Surveyor asked when she received any in-service training on the facility fall protocols, V3 stated, "I don't remember."

On 2/14/21 at 11:00 AM, surveyor observed V4 (Certified Nursing Assistant/CNA) in the dining area and was asked if she worked the day R1 fell and inquired as to duties today. V4 stated, "No I wasn't there. Right now we're getting everyone ready for lunch, so we put some of them in the dining room, because they have to be watched." Surveyor asked what she meant, V4 stated, "Well they're confused so we watch them, and we toilet them." Surveyor asked whether she knew or was told by of the nurses which residents were at risk for falls, V4 stated, "No, but they all are confused up here." Surveyor asked V4 if she was in-serviced or given instructions on how to keep the confused residents from falling, V4 stated, "I don't know, we just watch them a lot."

On 2/14/21 at 11:10: AM, surveyor asked V6 (CNA) if he was working the day of R1's fall, V6 stated, "I was working, but I was on break when it happened." Surveyor asked if he knew R1. V6 stated, "Yes, he was kind of confused. He would try to get up a lot." Asked on the day of R1's fall,

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whether he was assigned to watch the dining room, V6 stated, "We take turns and I just went on my break, but I think it was (V7-CNA) who was there when R1 fell." Surveyor asked whether he let anyone know he was leaving the floor to go on break, V6 stated, "No, it's on the schedule." Surveyor asked if he was instructed by the nurses or anyone in the facility about fall prevention, V6 stated, "I think he had a fall mat by his bed and a chair alarm for his wheelchair but I'm not sure what else we do."

A review of R1's care plan show no fall mats, chair alarms or any other safety devices used.

On 2/14/21 at 11:20 AM, surveyor asked V5 (CNA) about R1's fall incident. V5 stated, "When (R1) fell I was on my break. I told my coworker V6 and V7 about 11:00 AM and they said okay because someone has to be with R1 all the time. He was in his wheelchair, with his wheelchair against the wall ,over there (pointing to the location in the dining room area). As soon as I came back from break, R1 was already put back in bed after he fell. We always watch him but we can't restrain him, we just give him something to do like magazines. Most of the time he just sits out here in the dining room." Surveyor asked what R1's fall precautions were when he was in bed, V5 stated, "He didn't fall out of bed, he fell from his wheelchair and it happened when I was on break. V5 was here in the dining room and they said he stood up and the CNA couldn't catch him because she went to get something for another resident." Surveyor asked what fall prevention interventions were in place to keep R1 from falling, V5 stated, "He didn't have any. We were just supposed to watch him closely." Surveyor asked if he recalled who the nurse on duty was at the time of R1's fall, V5 stated, "It was

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a new nurse I know that, I think it was (V8)."

On 2/14/21 at 1:25 PM, V8 (RN) stated, "I was at the nursing station preparing my medications for the 12:00 PM "med-pass". I didn't see R1 fall because my cart was at the nursing station at the time and there's a wall that blocks part of the dining room so I couldn't see where R1 was sitting." Surveyor asked what she could recall about R1 and his behaviors, if any. V8 stated, "I didn't really know (R1) or that he was even a fall risk. I just started about a month ago in December 2020 when this incident happened. After (R1) fell we left him on the floor in the dining room, so we did not move him at first. We had the CNA's put him on a lift and placed him back in his room on his bed and applied ice on him. I gave him pain medications and I know he was on hospice and that he usually was in his room. (R1) is alert and oriented times 2 to 3 that's about what I know." When asked how many nurses were working on the floor when R1 fell on 1/25/21, V8 stated, "I was the only one on duty on the dementia unit and it was my first day out of general orientation working by myself . I didn't know the residents well." Surveyor asked if she knew, or if anyone of the nurses informed her that R1 was at high risk for falls, V8 stated, "No, no one ever told me that." Surveyor asked whether she received any formal in-service training from the facility on fall prevention. V8 stated she received no formal fall prevention in servicing. Surveyor asked whether she knew what fall prevention protocols were in place to keep R1 and any of the other residents on the dementia floor safe, V8 stated, "No. I was not given anything." Surveyor asked again whether during her orientation, whether any staff may have told her of any of the residents who were high risk for falls on the floor she served, V8 stated, "No sir, I

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was not told anything specific about R1 or any of the other residents on the floor R1 was on. I just know they are all pretty confused."

On 2/14/21 at 1:30 PM, V7 (CNA) stated, "I was in the dining room helping residents and (R1) was in the dining room sitting in his wheelchair .. He wasn't my resident, it was V5's (CNA) and he was on break and so was V6, the other CNA." Surveyor asked how many residents there usually were that were in the dining room during lunch time, V7 stated, "Sometimes 13 or 14, maybe more." When asked what happened on 1/25/21 when R1 fell, V7 stated, "We put all the residents in the dining room around 11:00 AM to get them ready for lunch and I was the only one in the dining room because like I said, V5 and V6 both went on break . I had to watch everyone. So I went to get some tea or hot water for another resident . when I turned around, R1 stood up and he fell down and I couldn't catch him." Surveyor asked whether she knew if R1 fell before this incident, V7 stated, "Yes, he fell in his room I think and he fell out in the dining room too before." Surveyor asked why R1 was unattended based on fall history, V7 stated, "He's not my resident and I was just watching everybody." Surveyor asked if she knew what to do with R1 to keep him from falling, V7 stated, "We are supposed to watch him and check on him, keep him calm, and keep the call light by him." Surveyor asked if there was a call light by R1, V7 stated, "No, there isn't one near him outside his room." Surveyor asked what in-service training she received to keep residents like R1 from falling, V7 stated, "We are just supposed to keep close watch on all of them, keep them calm like give them newspaper or something to do." Surveyor asked if R1 was provided any of these things, V7 stated, "No."

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On 2/14/21 at 12:10 PM, V2 (DON-Director of Nurses) stated, "I just started January 11th as the DON here, but I've been a DON elsewhere." Surveyor asked V2 to describe the nursing staff scheduling. V2 stated, "Nurses make the assignments for the CNAs. There's group 1, 2, and 3, which is how they schedule breaks. This was already in place when I got here. V8 was the nurse on duty when R1 fell on 1/25/21. She was new and a PRN (as needed) nurse." Surveyor asked V2 if she was on the floor when R1 fell. V2 stated, "No, I wasn't. I didn't observe it. I did the investigation though and reported it." Surveyor asked if she was aware of any fall risk interventions the facility utilized for high fall-risk residents including R1. V2 stated, "Well I know that we have the pharmacy review medications, we tried to monitor R1 closely and see if he needed to have 1:1 supervision." Surveyor asked if R1 required 1:1 supervision, V2 stated, "I'm not sure, but I know he had a history of falls." Surveyor asked what other fall prevention strategies she would put in place now that she was the new director of nurses, V2 stated, "Well, I know that we need to ensure the call light is in place and staff should watch residents at least every 3 to 4 hours every shift. We use side rails and increased toileting. We don't use any bed alarms or chair alarms, but I'll have to check what else we do." Surveyor asked V2 whether there were any other fall prevention strategies she learned as the head of the nursing department but could not offer any further fall prevention strategies. Surveyor provided V2 examples such as wedge cushions, pommel cushions or any other assistive devices that could have protected R1 or any fall-risk residents she had, V2 stated, "I don't think we used any of those on R1 or anybody here." Surveyor provided another

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example such as a pressure-activated wheelchair cushion alarm that could have been used on R1 to alert staff once he got up from his chair, V2 stated, "Like I said, we don't use alarms here." Surveyor asked if she knew what interventions were in place to prevent R1 from falling, V2 stated, "I don't know. Surveyor asked if she did the R1's fall investigation, V2 stated, "I did." Surveyor asked if she looked at the wheelchair R1 fell from and checked to see if it was locked or if it was in proper working order during her investigation, V2 stated, "No, I interviewed staff and we assessed the resident." Surveyor asked what interventions were implemented to keep R1 from falling, V2 stated, "I just know they're supposed to watch him closely."

Interview with V11 (Medical Director) on 2/15/21 at 12:55 PM stated, "I am the medical director and yes I was the attending physician for (R1). I saw him every month on follow up sometimes via tele-health. I was made aware of his falls and his high-risk for falls. I know that the nurses did daily meetings pertaining to his falls. He was declining and he had no ability for safety awareness. I was informed of the "big" fall in the dining room as he was sent out to the hospital based on my order. He was already declining and certainly this fall didn't help,but again, people fall and there is not much you can do as this population with dementia, you are going to expect multiple falls. Short of tying someone down which I'm not suggesting, (R1) would continue to fall and people with progressive dementia will fall. Surveyor asked whether they talked about staffing levels that may impact falls, V11 stated, "I thought you're only asking me about R1" Surveyor asked V11 if she was the medical director and oversaw all the residents, V11 stated, "Well, I'm unaware of who was watching (R1) at

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the time of the incident and I am not involved in staffing so I can't comment on that. We have monthly QA (Quality Assurance) meetings and yes I am involved in them. We meet about the first week of the month. I physically attend them and yes we do discuss falls. I'm certain V1 (Administrator) can provide you with minutes. I know we bring up the falls each month but I can't tell you if we do any changes to any interventions, that would be up to the facility."

2. R2 is a 58 year old resident with diagnosis of Dementia, Major Depressive Disorder and Anxiety Disorder. Facility records show R2 fell a total of 14 times during his stay at the facility. His most recent falls occurred on 1/31/21, 1/3/21, 6/21/20, 5/1/20 and 2/7/20.

R2's care plan last updated 2/1/21 states in part (but not limited to): R2 has history of multiple falls with no minor/major fall-related injuries related to history of falls, impaired balance, psychotropic drug use, cognitive and physical impairment secondary to dementia, anxiety, psychosis, limited range of motion of lower extremities.R2 was noted on the floor witnessed from his recliner chair (specialty) with no injury noted during this review.
Goal: I will not sustain serious injury through the review date. Interventions: Anticipate and meet the resident's needs; be sure resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Bed height to be placed where the floor mat is; Floor mats in place when resting in bed; Pommel cushion to the (specialty) recliner chair to minimize falling incident; PT/OT to evaluate current trunk control to determine which assistive device is most appropriate. Staff reminded to

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PLUM GROVE	24 SOUTH PLUM GROVE ROAD PALATINE, IL 60067

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S9999	Continued From page 12 place resident in the center of the bed. Nursing notes on 1/31/2021 showed: "Fall Description: Resident had a witnessed fall 1/31/2021, 5:45 PM. Location of fall: Dining Room. Resident was sitting on his (specialty) recliner chair in the dining room. NOD (Nurse on duty) was in nurse's station charting and noted resident sliding down from his (specialty) recliner chair. NOD (nurse on duty) ran to dining room and yelled for CNA to help residen,t but was not able to reach resident in time to prevent fall. Resident fell to the floor on left lateral position. Nurses notes on 1/3/2021 showed: "Resident had an un-witnessed fall 01/03/2021, 4:30 AM. Location of Fall: Resident's bedroom, at bedside, on padded floor mat. CNA began rounds, heard resident yelling, called to resident's room, resident found crawling on floor mat." On 2/14/21 at 11:15 AM, R2 was observed in the center of bedroom and was placed in a recliner that appeared to be elevated waist-high. R2 appeared agitated and was moaning and talking unintelligibly. There were no call lights within his reach . R2's left leg was dangling out of the reclining chair and he appeared precariously placed in the recliner. Surveyor called over V3 (RN) and asked about R2. V3 stated, "That is (R2) we put him in the (specialty) recliner chair because he is a fall risk and he's fallen several times. Surveyor asked how R2 could ask for help since there was no call light within R2's reach, V3 stated, "He doesn't use the call light, he's confused so we try to check on him a lot. Surveyor asked what kind of fall interventions she knew of they used for R2, V3 stated, "I think we use a fall mat on him when he's in bed." Surveyor asked V3 if she saw any in the room, V3 stated, "I	S9999		

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S9999	Continued From page 13 don't see any." Surveyor asked whether they might store the mats when not in use anywhere, V3 stated, "It would be folded up by his bed if we used it." Surveyor asked if there were any other safety devices used for R2 when in his reclining chair or if she saw any on him now, V3 stated, "There isn't any that I see, but I don't know what else they use. I just know they check on him frequently." Surveyor asked whether R2 should be placed in the center of the room like he is now, V3 stated, "No, he shouldn't be here like this." 3. R3 is a 78 year old resident with diagnoses of Alzheimer's Disease, Unsteadiness, Lack of Coordination, and Fracture of the left Femur. R3's care plan most recent update 10/29/20 states in part (but not limited to): "I have a history of falls related to cognitive impairment: poor safety awareness, unsteady gait and balance and constant wandering in the hallway. I have no safety awareness and would accidentally bump into things when I am walking around that may cause skin issues. (R3) was recently hospitalized and undergone a surgery to her right femur fracture. She is currently using a wheelchair with restrictions to walk. Goal: The resident's fall risk will be reduced by the review date. Interventions: I will not have complications from my restrictions of walking; anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance; Bed height to be placed where my feet are flat on the floor. Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing; The resident needs to be evaluated for, and supplied such as wheelchair and walker. Re-evaluate and as needed for continued	S9999		

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S9999	Continued From page 14 appropriateness and to ensure least restrictive device or restraint; follow facility fall protocol." Nurses notes showed: "Resident had a witnessed fall 10/16/2020 5:10 AM Location of Fall: Dining room/common area. Resident had a witnessed fall by CNA. CNA states resident hit head on corner of table. Resident was walking and fell. On 10/19/2020, 3:54 PM, MDS Progress Note. Late Entry: Narrative: resident unable to tell if she had pain during the look back period. Resident was send out to the ER due to fracture in the femur during this assessment, continues to require moderate to extensive assistance due to poor safety awareness and confusion. Resident needed verbal cuing during her Activities of Daily Living. Resident had fall which she obtained injury and she was sent out to the hospital." Facility incident report dated 10/19/20 states in part (but not limited to): Resident: (R3) Diagnosis: Alzheimer's Dementia, Lack of coordination and unsteadiness, restlessness and agitation. Description of occurrence: Nurse noticed a slight limp while resident was ambulating in the hallway. Resident had a fall 3 days prior without notable change in range of motion. Injuries: Incomplete non-displaced fracture involving the right subcapital femur. On 2/14/20 at 12:20 PM R3 was seated in the dining room area eating lunch. She appeared very confused and agitated and was pushing her food around on her plate and was repeating "Come here, come here" to no one in particular. There were 14 other residents seated in the dining area with lunch trays placed in front of each resident. Surveyor asked V3 how many residents were usually in the dining room at this	S9999		

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S9999	Continued From page 15	S9999		

time having their meal, V3 stated, "This is about the usual. We have these 14 or so residents and we have some seated outside their rooms and there's about three others in that small area in front of the nursing station." Surveyor asked about R3, V3 stated, "Yes she's a fall risk. She had a fracture recently but that's all I know." Surveyor asked if there were any type of devices used on R3 as she sat on the edge of her wheelchair." V3 stated, "I'm not sure what else we'd use on her." Surveyor asked V3 whether she's ever been instructed to use a wedge cushion or pommel cushion to keep R3 from sliding down, V3 stated, "I've never seen that on anyone here but I will let management know your concerns."

4. R4 is a 72 year old resident with diagnoses of Dementia, Abnormality of Gait and Mobility, and restlessness and agitation.

R4's most recent care plan dated 1/4/21 shows in part (but not limited to): "I have a history of falls related to muscle weakness, unsteady gait, impaired balance, osteoarthritis, history of falls, psychotropic drug use, incontinence, poor safety awareness. Goal: I will not have any unavoidable falls through the next review date. Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to request for assistance. Bed height to be placed where my feet are flat on the floor. Ensure that the resident is wearing appropriate footwear describe correct when ambulating or mobilizing in wheelchair. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible."

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S9999	Continued From page 16 Facility incident dated 12/24/20 report stated, "Resident had an un-witnessed fall 12/24/2020 11:15 PM Location of fall: resident's room at her bedside. Heard the loud voice "help", went to her room and found lying by her bedside. Helped resident sit on the bed and assessed range of motion, obtained vital signs. Administered pain medication for pain." Nurses note written by V3 (RN) stated, "Observed resident with guarded movement of the right arm, pain with movement 4/10, palpable pulses, no discoloration or bruising at right arm noted. DON and POA made aware of the resident's current condition." Facility incident report completed by V1 (Administrator) states in part (but not limited to): Resident: (R4) "Nurse noted a complaint of pain and inability to raise arm. No pain noted since fall on 12/24/20. Injuries: Superior dislocation of humeral head." 5. R5 is a 61 resident with diagnoses of Alzheimer's Disease, Abnormality of gait and mobility. Facility fall occurrence records show R5 fell 7 times (1/19/21, 1/6/21, 1/4/21, 11/14/20, 11/6/20, 9/2/20, and 6/15/20). Facility fall occurrence records showed: "Resident had an un-witnessed fall 01/19/2021 4:40 PM Location of fall: Dining room. Resident was walking when he turned around and trying to sit on the chair and missed it. He sat on the floor." "Resident had a witnessed fall 01/06/2021, 5:20 PM Location of fall: common area, dining room. Resident ambulating shuffling both feet, making a turn, aiming to sit on chair and missed, hit back on wall then slide to floor." "Resident had an un-witnessed fall 01/04/2021,	S9999		

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S9999	Continued From page 17 5:15 PM Location of fall: Outside of resident's room, near dining room, in the hallway. CNA stated that resident had "fell/tripped," and was lying on their side when they fell. Resident ambulated and stood up without assistance. No pain or apparent physical injuries noted." R5's care plan states in part (but not limited to): "I have potential for minor/major fall-related injuries related to unsteady gait and poor safety awareness. R5 like to walk around the hallway. He has a wander guard to alert staff if (R5) is near the elevator when he wanders around. Goal: I will be free from minor/major fall-related injuries through the next review date. Interventions: Anticipate and meet the resident's needs; be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance; Bed height to be placed where my feet are flat on the floor; Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs; Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility; Ensure that The resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair; The resident needs a safe environment with: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night, personal items within reach." Facility policy dated 11/21/2017 titled "Fall Prevention Program" states in part (but not limited to): "Purpose: to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by	S9999		

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S9999	Continued From page 18 assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. The fall prevention program includes the following components: Methods to identify risk factors, residents at risk, assessment time frames, immediate change in interventions that were successful; communication with direct care staff members. Care plan incorporates: Identification of all risk/issue, addresses each fall, interventions are clanged with each fall as appropriate, preventative measures. Standards: A fall risk assessment will be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident; Safety interventions will be implemented for each resident identified at risk; the admitting nurse and assigned CNA are responsible for initiating safety precautions at the time of admission. All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained. Fall/safety interventions may include but are not limited to: Direct care staff will be oriented and trained in the Fall Prevention Program; the time of admission and in accordance with the plan of care the resident will be oriented to use the nurse call device. The nurse call device will be placed within the resident's reach at all times. Resident will be observed approximately every two hours to ensure the resident is safely positioned in the bed or a chair and provide care as assigned. Residents who require staff assistance will not be left alone after being assisted to bathe, shower, or toilet. Nursing personnel will be informed of residents who are at risk of falling." (A)	S9999		