Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007272	A. BUILDING: ______ B. WING ______	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE WILLOWS	3520 NORTH ROCHELLE PEORIA, IL 61604

(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 Annual Health Survey Facility Reported Incident of 4/13/2021/IL132965	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.610a) 300.696c)2) 300.1210a) 300.1210d)2)3)5) 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 300.696 Infection Control	S9999	**Attachment A** **Statement of Licensure Violations**	

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c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340):

2) Guideline for Hand Hygiene in Health-Care Settings

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

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

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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 regulations are not met as evidenced by:

Based on observation, record review and interview, the facility failed to identify residents as being at risk for pressure ulcer development, timely obtain pressure ulcer treatment orders from a Physician, perform routine skin assessments, implement pressure relieving interventions, and perform proper hand hygiene during wound care, for three of seven residents reviewed (R21, R40, R66) for pressure ulcers in a sample of 40. These failures resulted in R21 developing a Stage 4 pressure ulcer on right ankle and right first toe, R66 developing a Stage 4 pressure ulcer on the right hip, and R40 developing a Stage 3 pressure ulcer on the right ischium.

Findings include:

The facility's Skin Treatment Protocol (undated) documents, "Decubitus ulcers are commonly referred to as bedsores or pressure sores. Pressure sores are usually formed when the skin breaks down because the resident remains in the same position for an extended period of time. When a resident remains in the same position for an extended period of time, there is a loss of

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S9999	Continued From page 4 circulation to that area, which destroys the tissues. The most common site of pressure sore is where the bone is near the surface of the body. These include the back of the head around the ears, elbows, shoulder blades, backbone, hips, knees, heels, ankles, toes, and under the breasts. The comprehensive assessment and plan of care determines the amount of care needed by each individual resident to ensure that a resident who enters the facility without a pressure sore does not develop pressure sores unless the individual's clinical condition demonstrates that they are unavoidable, and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. Clinical conditions may demonstrate pressure sores were unavoidable only if preventive care was provided. Adequate preventive care includes turning and proper positioning, application of pressure relief devices, providing clean and dry bed linens, and maintaining adequate nutrition. Resident assessment (Braden Scale) identifies residents at risk of developing pressure sores and routine preventive care is provided. Based on the outcome of the comprehensive assessment and as change warrants, skin deficits are addressed as appropriate with the Physician. Treatment is provided as prescribed and a plan of care is developed. For a resident who upon admission to the facility did not have a pressure sore and now has one, resident assessment determines if the pressure sore was unavoidable, such as: 1. Was the resident identified as being at risk for pressure sores? 2. Was routine preventive measures and care specific measures to addressing the resident's unique risk factors identified? For all residents who have pressure sores identify: 1. Are measures to assist healing	S9999		

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S9999	Continued From page 5 necessary (relieving pressure, moving the resident without casing shearing, applying a medicated dressing)? 2. Are measures to prevent infection necessary? 3. If the pressure sore is not healing, is getting larger, and/or signs of additional skin breakdown are evident, have alternative interventions been considered or attempted? Preventions of Pressure Ulcer: 1. Assess for risk of pressure ulcer development by completing the Braden Assessment. a. For those residents identified at moderate or high-risk preventative care plan measures will be put in place and the skin observation tool will be performed on a weekly basis. 2. Assess and identify complicating conditions that may contribute to pressure ulcer development. 3. Identify additional risk factors that may exist and address as needed on the care plan. 4. Explain care plan approaches to the resident. 9. Use pressure reducing or relieving devices as necessary. 10. Establish a turning and positioning routine in bed and chair to meet the resident's needs. 11. Position with appropriate surfaces to protect bony prominence's. Pressure sores are the most serious skin condition for the resident. Report any signs of a developing pressure sore to the staff/charge nurse immediately." 1. The Electronic Medical Record documents R21 was admitted to the facility on 2/24/2020 with the diagnoses of Peripheral Vascular Disease and Schizophrenia. A Minimum Data Set assessment, dated 5/22/20, documents R21 has inattention and disorganized thinking, requiring the physical assistance of one person for dressing, hygiene, bathing and transfers. Progress notes dated 3/13/20 document R21 developed a "scabbed area on the right outer	S9999		

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ankle" that measured 0.1 cm (centimeters) x 0.2 cm, along with another "scabbed area" to the top of the right foot, that measured 0.2 cm x 0.1 cm. Treatment Administration Records document those areas as being treated with skin prep once daily until they healed on 3/25/20. Progress Notes dated 9/15/20 document R21 developed another area near the arch of his right foot, measuring 2.0 cm x 0.1 cm, which was treated with betadine and covered with a foam dressing daily (from 9/16/20 to 10/12/20), and R21 was "educated on the importance of not sleeping with socks and shoes on." R21's Plan of Care at the time of both occurrences failed to identify R21 as at risk for impaired skin integrity, that R21 developed actual skin impairment on his right foot, or that R21 was to not sleep with his socks and shoes on.

On 10/28/20, Progress Notes document, "noted an open area to (R21's) right heel. Upon assessment this writer noted resident in bed asleep (with) shoes and socks on. This writer educated resident on importance of not sleeping in footwear to which (R21) replied 'it's too hard to take my shoes on and off.' This writer re-educated resident on use of call light and importance of asking staff for assistance. Resident has what appears to be an unstageable pressure ulcer to right ankle that measures at 3 x 2 cm."

An Initial Wound Evaluation and Management Summary, dated 10/29/20 by V8 (Wound Doctor), documents R21 as having a wound determined to be from pressure, described as "unstageable (due to necrosis) of the right, posterior ankle," measuring 2.0 cm x 1.3 cm x unmeasurable depth. V8 instructed staff to clean the wound, dry, apply Calcium Alginate with Silver and cover

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with a border foam dressing daily, off-load wound and utilize a sponge boot.

Nursing Progress Notes, Skin Observation Tools or Skin/Wound Notes do not document further assessment of R21's right posterior ankle wound until over two weeks later, on 11/16/20. The 11/16/20 Skin Observation Tool documents R21's right ankle wound as 1.5 cm x 1.0 cm, and identifies a new wound on the right great toe measuring 0.4 cm x 0.4 cm. There is no documented evidence that the Physician was notified of the development of a new wound on the right great toe, or that a treatment was initiated at that time.

A Wound Evaluation and Management Summary, dated 11/19/20 by V8, documents R21 as having a Stage 4 Pressure Wound on the right posterior ankle, measuring 1.5 cm x 1.0 cm x unmeasurable depth, and a unstageable pressure ulcer of the right, dorsal, first toe, which measured 0.4 cm x 0.4 cm x unmeasurable depth. V8's documentation indicates both wounds required surgical debridement at that time, and treatment was changed to applying collagen sheets daily to the wounds, with instructions to continue to use a sponge boot and off-load R21's wound. R21's Plan of Care failed to identify that R21 developed actual skin impairment on his right foot, was to not sleep with his socks and shoes on, was to utilize a sponge boot and off-load the wound.

On 12/03/20, documentation indicates a Plan of Care was developed related to R21's pressure ulcers on the right ankle and right first toe, with the following interventions: Staff will assess wounds routinely, document and notify (Physician) of change in condition, Staff will

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complete treatments as they are ordered by the wound (Physician), Staff will ensure that (R21) is wearing clean socks with properly fitting footwear.

On 12/18/20, a Wound Care Telemedicine Follow Up Evaluation, documents R21's right ankle wound as a Stage 4, measuring 1.9 cm x 1.5 cm x unmeasurable and the unstageable pressure ulcer of the right, dorsal, first toe, measuring 0.4 cm x 0.4 cm x unmeasurable. R21's Plan of Care still failed to identify that R21 was to not sleep with his socks and shoes on, was to utilize a sponge boot and off-load the wound.

The most recent Wound Evaluation and Management Summary by V8, dated 4/22/21, documents R21 now has the following wounds on the right foot: 1. Stage 4 Pressure wound of the dorsal first toe (0.3 cm by 0.3 cm by unmeasurable depth), 2. Wound of the medial heel (0.7 cm x 1.0 cm x unmeasurable depth), 3. Wound of the lateral heel (0.2 cm x 0.1 cm x 0.1 cm). Documentation further indicates the right first toe and medial heel required surgical debridement on 4/22/21 and V8's recommendations for the Plan of Care was to "Off-load wound; Sponge boot."

On 4/26/21 at 10:11 am, R21 was sleeping in bed with shoes on his feet, which were resting directly on the mattress, with no off-loading.

On 4/28/21 at 1:11 PM, R21 was sleeping in bed wearing dirty socks and his feet resting directly on the mattress. R21 stated he tries to not wear his shoes to bed anymore and denies ever having a sponge boot to wear.

On 4/29/21 at 08:50 am, V9 (Licensed Practical Nurse) stated R21's wounds were created by

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pressure from sleeping in bed in his shoes. V9 stated R21 has never had a sponge boot for the right foot. At that time, V9 performed wound care to the right great toe and right heel. V9 identified three new open areas on the right foot, located on top of the second and third toe and the top of the foot near the ankle.

On 4/29/21 at 9:40 am, V3 (Assistant Director of Nursing) stated it was determined that R21's right foot pressure ulcers were caused by R21 sleeping in his shoes. V3 stated R21 should have been identified as at risk for the development of pressure ulcers, due to his admitting diagnosis of Peripheral Vascular Disease. V3 concluded that R21 should have had a Plan of Care with pressure ulcer prevention interventions developed in March of 2020 when R21 first developed open wounds on his feet. V3 stated the Treatment Nurse is typically responsible for developing a Plan of Care related to skin issues. V3 stated R21 never had a sponge boot or off-loading measures implemented for the right foot, as ordered by V8 on 10/29/20. V3 was unaware that V8 wanted R21 to have a sponge boot for the right foot and explained that up until recently she and V2 (Director of Nursing) did not have access to V8's documentation.

2. R66's Nursing Note dated 7/30/2020 at 11:28 PM documents, "(R66) admitted to the hospital for the diagnosis of a left femoral neck fracture (left hip fracture)."

R66's Nursing Note dated 8/10/2020 at 3:18 PM documents, "(R66) readmitted to facility after return from the hospital post left hip arthroplasty (surgical hip repair)."

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R66's Minimum Data Set Assessment dated 10/1/20 documents R66 required extensive assistance of one person physical assist for bed mobility, extensive assistance of two person physical assist for transfers, was not a risk for development of a pressure ulcer, did not have a pressure reduction device to the bed or chair, and was not on a turning and repositioning program."

R66's Braden Scale for Predicting Pressure Sore Risk dated 8/10/20 (After sustaining the right hip fracture) documents R66 is not at risk for developing a pressure ulcer.

R66's Medical Record dated 8/10/20 (date of re-admission) through 11/12/20 does not include R66 having a turning and repositioning program until 11/12/20.

R66's Plan of Care dated 4/8/20 through 10/20/20 does not include pressure reducing interventions or wound treatment interventions until 10/20/20.

R66's Wound Evaluation and Management Summary dated 10/08/20 and signed by V8 (Wound Physician) documents, "(R66) has a stage two pressure wound of the right hip for a least one day in duration. Wound size 3.0 cm (centimeters) x 4.0 cm x 0.1 cm. Exudate: Light sero-sanguineous."

R66's Wound Evaluation and Management Summary dated 10/16/20 and signed by V8 documents, "Unstageable (due to necrosis) pressure ulcer of the right hip. Wound size 4.0 cm x 6.5 cm x non measurable depth. Exudate: Moderate sero-sanguineous. Necrotic tissue 70 percent. Wound progress: Deteriorated."

R66's Wound Evaluation and Management

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S9999	Continued From page 11 Summary dated 4/22/21 and signed by V8 documents, "Stage four pressure wound of the right hip. Etiology: Pressure. Minimum Data Set stage: Four. Duration: Over 193 days. Wound Size: 0.5 cm x 0.5 cm x 0.2 cm. Slough: 20 percent. Indication for Surgical Excisional Debridement Procedure: Remove necrotic tissue and establish the margins of viable tissue. The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, a blade was used to surgically excise 0.05 cm of devitalized tissue including slough." On 04/27/21 at 09:34 AM V12 (Agency LPN) removed R66's pressure ulcer dressing and then cleansed R66's right hip pressure ulcer with wound cleanser. R66's pressure ulcer dressing contained a moderate amount of reddish-yellow drainage. R66's right hip pressure ulcer was yellow in color and measured 0.5 cm (centimeters) x 0.5 cm x 0.2 cm depth in the center with 3.5 cm deep red colored scar tissue surrounding the ulcer. V12 then applied calcium alginate to the wound and covered the wound with a bordered gauze. R66 stated, "I got the sore from laying in bed too long on that side. I broke my hip and could not move. It hurts." On 04/27/21 at 11:40 AM (V3) (Assistant Director of Nursing/ADON) stated, "(V8) documented (R66's) wound to the right hip was due to pressure. The Braden Score Assessment dated 8/10/20 was inappropriately coded and should have been scored at a "14" which would have indicated that (R66) was at moderate risk of developing a pressure ulcer. (R66) should have been put on a turning and re-positioning every two hours program and weekly skin checks should have been done after (R66) returned from	S9999		

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the hospital with a hip fracture. "

On 04/28/21 at 08:53 AM V3 stated, "No pressure relieving interventions were implemented to prevent pressure ulcers after (R66) broke his hip until after he developed the pressure ulcer."

On 04/27/21 at 02:13 PM V1 (Administrator) stated, "(R66) was not put on a turning and repositioning program until 11-12-20 after the pressure ulcer already developed."

3. R40's Braden Scale for Predicting Pressure Sore Risk assessment, dated 2/15/21, documents that R40 is at risk for developing pressure ulcers.

R40's Skin Observation Tool, dated 2/15/21, documents, "(R40)'s skin is warm, dry, intact. No new skin issues noted."

R40's Electronic record has no documentation of a skin check being completed on R40 until 3/11/21. R40's Skin/Wound Note, dated 3/11/2021 at 3:23 PM, documents, "New pressure wounds to right ischium and buttock."

R40's Wound Evaluation and Management Summary, dated 3/12/21, documents, "Stage 3 pressure wound of the right ischium measuring 1.8 cm (centimeter) x 1 cm x 0.2 cm."

R40's TAR (Treatment Administration Record), dated 3/2021, documents that a treatment was not initiated until 3/13/21 for R40's pressure ulcer.

R40's Wound Evaluation and Management Summary, dated 4/22/21, documents, "Stage 3 pressure wound of the right ischium measuring 0.5 cm (centimeters) x 0.3 cm x 0.2 cm for

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SHARON HEALTH CARE WILLOWS	3520 NORTH ROCHELLE PEORIA, IL 61604

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greater than 38 days. Dressing treatment plan: Primary dressings: Alginate calcium with silver apply once daily for 23 days, secondary dressing: gauze island with border apply once daily for 23 days. Recommendations: Off load wound; Reposition per facility protocol.)

R40's Physician's orders, dated 4/21, document the following orders: (3/12/21) Silver Alginate to Right Ischium and Right Buttock Wounds every day shift for pressure wound, cleanse wounds with normal saline, pat dry, cover with silver alginate and large foam dressing daily.

On 04/28/21 at 10:17 AM, V7 (LPN-Licensed Practical Nurse) removed a border foam dressing from R40's right ischium dated 4/27/21. R40 had a small irregular shaped open area with depth with reddened surrounding tissue. The skin between R40's right and left buttock was significantly reddened. V7 cleansed R40's right ischium again with normal saline. V7 proceeded, with the same gloves on, to apply antifungal cream to her fingertips and apply the cream to R40's reddened right and left buttocks area. Then, V7 removed her gloves and applied a new pair without washing/sanitizing her hands. V7 applied a square piece of calcium alginate with silver to R40's right ischium and covered it with a border foam dressing.

On 04/28/21 at 10:45 AM, V7 stated, "I didn't wash my hands when I changed my gloves since I was working with the same resident."

On 04/29/21 at 08:44 AM, V3 (Assistant Director of Nursing) stated that skin checks should be done weekly and that was not occurring for (R40), and if they were the pressure ulcer could have been identified prior to being a Stage 3 (pressure

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ulcer). V3 also stated that a Physician ordered treatment should have been initiated when (R40's) pressure ulcer was identified.

(B)

2 of 2

300.610a)
300.1210b)
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

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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:

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 months.

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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 regulations are not met as evidenced by:

Based on interview and record review, the facility failed to thoroughly investigate a fall and implement interventions to prevent further falls for 2 of 3 residents (R64 and R65) reviewed for falls in a sample of 40. These failures resulted in R65 experiencing subsequent falls leading to a nondisplaced fracture involving the fibular tip.

Findings include:

The Facility's Resident Accident/Incident Safety Policy, undated, documents the following: "It is the policy of (the facility) to provide a safe environment for all residents. We understand there will be times when best efforts will not be enough. Accidents will happen. Residents will fall. For any incident/accident, involving a resident, the following protocol will be followed: Complete an incident/accident report. This includes an investigative report, and for falls, a fall assessment. The report is presented to the DON (Director of Nursing) for further investigative review, and initiation of additional measures as necessary."

The Facility's Procedure for Responding to a Resident Fall, dated 7/18/2019, documents the following: "Once the resident's immediate needs have been attended to, document the incident by

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reporting the facts. Record all objective data including the time the resident was discovered, the resident's condition, who was notified and when, and the follow up treatment. Also, record any subjective data concerning the fall, such as comments made from the resident and witnesses verbatim and attribute them accordingly. An incident report should be made according to facility policy. The nursing staff should notify the facility's supervisor of the fall so he or she can direct staff to implement interim interventions to protect the resident from another fall or injury. This information should be documented in the resident's record. IDT (Interdisciplinary team) will complete the thorough investigation to determine contributory causes for the fall and what actions should be taken to minimize the risk of a future fall, review care plan and make revisions if needed."

R65's quarterly and annual MDS (Minimum Data Set) Assessment dated 3/3/2021 and 12/30/2020 document R65 has a BIMS (Brief Interview of Mental Status) of 6 (scale of 0-15, 15 being mentally intact).

R65's Incident Investigation Report dated 12/24/2020 documented the following: "(R65) noted on the floor on D hall. Wheelchair behind him. He stated he was picking up something from the floor and fell from his wheelchair." This report does not include root cause analysis or interviews from staff.

R65's Incident report dated 12/30/2020 documents the following: "(R65) was noted on the floor lying on his back. He stated he was trying to lay in his bed." This same form documents the following: "Action Plan: follow any recommendations from the hospital upon return.

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This investigation did not include interviews, root cause determination of R65's fall or interventions to prevent further falls.

R65's Incident Report dated 4/13/2021 documents the following: "Nurse noted (R65) with pain and swelling to left ankle. Non Displaced fracture involving the fibular tip. (R65) reports that he injured ankle when he transferred self from wheelchair to bed. Intervention: Refer to (local orthopedic doctor wrap with bandage) until further recommendations are received. Follow all recommendations." This report did not document an intervention to prevent further falls or interview to determine the root cause. R65's X-ray dated 4/13/2021 documents the following: "Impression: Nondisplaced fracture involving the fibular tip."

R65's current fall care plan was reviewed and did not include interventions to prevent further falls for R65's falls dated 12/30/2020 and 4/13/2021.

On 4/28/2021 V3 ADON (Assistant Director of Nursing) stated the following regarding R65's falls on 12/30/2020 and 4/13/2021: "There were no immediate interventions put in place to prevent further falls nor were additional interviews to determine root cause were not conducted."

2. On 04/26/21 at 10:48 AM, R64 stated, "I had to go to the restroom really bad one night. I was going to soak everything. I had my call light on in the night waiting for help. There isn't enough staff to help. You're lucky to get help. I had to go to the bathroom so bad I couldn't wait any longer so I tried to get into my wheelchair on my own. I fell trying to get into my wheel chair. I called for help when I was on the floor, and it took a while for them to get to me. I wet myself waiting for the staff to come to me when I was on the floor. I

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couldn't get myself up without help. I ended up breaking my left ankle."

The facility's Incident Report Telephone to State Agency, dated 1/25/21, documents, "R64 reported that she had a fall during the night of 1/24/21. Reported pain 10/10 to the left side, left hip and left ankle. Nurse reported no edema other than baseline edema to left ankle. Noted small amount of bruising to left upper thigh. R64 requested X-ray of her left hip and left ankle. Type of Injury: Fracture: Left lateral and medial malleolus."

R64's Left Ankle X-ray Report, dated 1/26/21, documents, "Impression: The visualized osseous structures demonstrate acute fractures involving the left lateral and medial malleolus. Associated soft tissue swelling is noted. Continued close clinical correlation is advised and orthopedic consultation is recommended."

R64's Incident Investigation Report, dated 1/27/21, documents that R64 reported the fall on 1/24/21 at 12:34 p.m. Injuries: pain/bruising. R64 reported fall during the night and reports pain to left hip. X-ray obtained. Fall reported on 1/25/21. The investigation report had no documentation of staff and/or resident interviews nor of a new fall intervention.

R64's care plan, dated 3/11/21, has no documentation of a fall intervention to prevent future falls for R64 following the fall on 1/24/21.

On 04/29/21 at 09:07 AM, V3 (Assistant Director of Nursing) stated that "(R64) would have needed help to get up from the floor, (R64) can't get up without help. I questioned this when (R64) told me she fell the night before and no one knew

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anything about it. I didn't document any staff interviews nor did I interview any residents either."

On 04/29/21 at 9:28 AM, V6 (Care Plan Coordinator) stated that R64 did not have a new intervention implemented after her fall with a fracture.

(B)