STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004832	A. BUILDING: _____ B. WING _____	C 09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY CHICAGO WEST	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2286663/IL150391	S 000		
S9999	Final Observations Statement of Licensure 1 out of 3 Violations 300.610a) 300.1210b) 300.1210d)6) 300.3210t) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These Requirements were NOT MET as evidenced by: Based on interview and record review, the facility failed to keep one resident (R5) free from physical abuse. This failure affected one of three residents (R5) reviewed for physical abuse that sustained injury/wounds to both knees, swelling and redness of left eye and a small scratch under left eye. This failure has the potential to affect all 180 residents residing in the facility. Findings include: R4's medical record showed that R4 was admitted to the facility initially 11/18/2021. Last admission date was 08/22/22. R4's listed diagnosis includes but not limited to other specified Abnormal Immunological findings in	S9999		

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S9999	Continued From page 2 serum, Alcohol Abuse Uncomplicated, Nicotine dependence, cigarettes uncomplicated, Other Psychoactive Substance Abuse in remission, and Major Depressive Disorder Recurrent, mild, Opioid Dependence uncomplicated, and Opioid use unspecified, uncomplicated. R4's Minimum Data Set (MDS) dated 7/13/2022, Section C-brief interview for mental status summary score is (06) indicating R4 is cognitively impaired. R5's medical record documented that R5 was last admitted 05/09/22. Diagnosis list includes but not limited to Epileptic Seizures related to external causes not intractable without status Epilepticus, Unilateral primary Osteoarthritis Left Knee, Alcohol Abuse, Effusion Left Knee, Acute Embolism and Thrombosis of Right Femoral Vein, Other Chondrocalcinosis Right Knee. R5's Minimum Data Set (MDS) dated 07/16/22, Section C-brief interview for mental status summary score is (11) indicating R5 is moderately impaired. R5's medical record progress notes and POS (Physician Order Sheet) showed the following documentation: 1.Review of R5's progress noted documentation dated 08/15/22 timed 22:43 (10:43pm) V12 LPN (Licensed Practical Nurse) documented in part that R4 struck peer (referring to R5) several times in the face. R4 was assessed and marks were noted to left elbow. 2.V16 documented on 08/15/22 that the reason for report was due to "Aggressive and threatening behavior towards other specific resident	S9999		

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S9999	Continued From page 3 escalated when (R4) started to get physically aggressive. At 2130-2140 (9:30pm-9:40pm) R4 came up to another resident and started to punch repeatedly and pull (R5) off the wheelchair. 3.V26 LPN (Licensed Practical Nurse) for R5 on the day of incident documented that "writer was informed by staff that resident (R5) had a physical altercation with peer (R4) on the courtyard. Resident (R5) was immediately separated and placed on 1:1. Resident (R5) was assessed by writer(V26) upon entering the courtyard. Writer (V26) noted swelling to the left eye and a small scratch under left eye. Left eye is red. No other bruise noted. 4.V20's documentation in R5's progress note dated 08/16/22 timed 8:50am documented that "this writer did body assessment this morning on resident. Resident (R5) only noted to have sores on both knees no other injury noted". 5. V4 (wound care Nurse) documented that on 08/17/22 at 1:07pm that R5 had a skin tear to left and right knee with wound care department will be monitoring. According to facility investigation reviewed, V1 (Administrator) documented on 8/18/2022 in part that V24 (Security guard) heard the yelling and when V24 approached, V24 immediately intervened and called for backup. V24 did not observe any physical contact between R4 and R5. V1 documented that based on known facts, the following conclusions have been determined that the allegation of physical abuse is unsubstantiated because R4 did not have any physical contact with R5.	S9999		

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S9999	Continued From page 4 On 08/24/22 at 3:14pm, interview conducted with V1 regarding the facility investigation of physical abuse on 8/15/2022. V1 stated R1 was a witnessed to an abuse situation and R1 was not abused but saw the altercation between R4 and R5. R1 medical record documents admitted 8/11/2022. R1's diagnosis includes but not limited to Obesity, unspecified, Type 2 Diabetes Mellitus with Hyperglycemia, Essential Hypertension R1's Minimum Data Set (MDS) dated 8/18/2022, Section C-brief interview for mental status summary score is (14) indicating R1 is cognitively intact. On 08/24/22 at 4:27pm, R1 was asked regarding the incident R1 witnessed between R4 and R5 on 8/15/2022. R1 explained that some of the residents were on the patio (Smoking Area) smoking. R1 stated, "I (R1) witnessed R4 and R5 arguing and R4 started hitting R5 in the head, face and (R4) threw (R5) on the floor from the wheelchair". R1 stated, "R4 continued to hit R5 while on the floor". R1 stated, "There was no staff around at the time, so I (R1) had to call other residents that were present to assist me (R1) in separating R4 and R5 while one resident was yelling for the staff". R1 stated, "By the time the staff showed up, R5 was on the floor bruised on the knees, face punched and swollen". On 08/25/22 at 12:12pm, interview with R5 regarding the physical altercation with R4. R5 stated that someone (referring to R4) turned me over from my wheelchair and I (R5) fell and hurt my legs. R5 touching the face and forehead said (R4) hit me in my face my head and knock me on	S9999		

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S9999	Continued From page 5 the floor. At 12:17pm R5 pulled his pants leg up and showed the surveyor his bilateral knees with V20 LPN (Licensed Practical nurse) present at the time. Surveyor observed dressings on both knees of R5. V20 then told the surveyor that (R5) was in an altercation with another resident (referring to R4) and was thrown on the floor from his wheelchair and R5 got injured on both knees. When V20 tried to touch the left knee R5 clinched and stated it hurts. R5 showed facial grimaces that reflect pain and told the surveyors that it is not fair for (R4) to hit me like that. On 08/25/22 at 12:25pm, interview conducted with R4 regarding physical altercation with R5. R4 stated that, I (R4) was sitting there on the patio talking. R4 stated, "He (R5) came over there, and things don't look right anymore, no one hits me and gets away". R4 stated, "R5 picked up this big plastic yellow cone (referring sign used by housekeeping) so I blocked him (R5), and I lost my temper when R5 hit me". R4 stated, "I (R4) really did not hit him as hard as I could, but I gave him one on his mouth and I threw him out of the wheelchair. (R5) was in a wheelchair which doesn't matter to me. I (R4) then see paramedics and they said the police is coming and I (R4) should follow them to the hospital". They (referring to paramedics) said they will bring me back after seeing the doctor. R4 stated, they (paramedics) said they will strap me (R4) up if I (R4) don't follow them. On 08/25/22 at 2:51pm, V4 (wound care Nurse) presented R5's bilateral knee wound care assessment dated 08/17/22 timed 1:07pm. V4 documented in part that he (V4) was notified by the floor nurse of a possible wound on (R5) Legs. Upon assessment noted skin tear to (R5) left and right knee. V4 stated the knees were not done	S9999		

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S9999	Continued From page 6 until 08/17/22 because the wound care department was not notified until 08/17/22. Left knee Measurement 1.00cm (Centimeter) in length, 0.80cm width and 0.10cm in depth. Right knee Measurement 2.00cm length x 2.00cm width x 0.10cm depth. R5's treatment order dated 8/17/2022 showed orders for right knee to Cleanse with NSS (Normal Saline Solution) or wound cleanser, pat dry, skin prep peri wound, apply xeroform, and cover with a dry dressing 3x week / PRN (As needed) every day shift every Mon, Wed, Fri for To Promote Wound Healing and as needed for To Promote Wound Healing. Left knee order read to cleanse with NSS or wound cleanser, pat dry, skin prep peri wound, apply xeroform, and cover with a dry dressing 3x week / PRN every day shift every Mon, Wed, Fri for To Promote Wound Healing On 08/30/22 at 12:21pm, R6 was in her room in a wheelchair. Surveyor asked R6 regarding the 08/15/22 physical altercation between R4 and R5. R6 stated, "R4 was the aggressive one and he hit R5 in the head and kicked R5 while R5 was lying on the floor". R6's Minimum Data Set (MDS) dated 7/08/2022, Section C-brief interview for mental status summary score is (15) indicating R6 is cognitively intact. On 08/30/22 at 12:24pm, interview conducted with R7 regarding the physical altercation between R4 and R5. R7 stated, "The residents were on the smoking patio smoking when R4 attacked R5. R4 was hitting R5 and throwing R5 out of the wheelchair to the floor". R7 stated, "R4 was kicking R5 on the head and the body and because the staff was not around the other resident had to hold R4 away from R5". R7	S9999		

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S9999	Continued From page 7 stated, "There was no security guard at the time so one of the residents had to run and called the security staff". R7's Minimum Data Set (MDS) dated 6/22/2022, Section C-brief interview for mental status summary score is (12) indicating R7 is mildly impaired. During this investigation calls were placed to V16 (RN), V24 (Security Guard), and V26 (LPN) with no return phone call. The facility Abuse Prevention Program policy presented documented in part that residents have the right to be free from abuse and this includes but not limited to any physical abuse. The purpose of this policy and abuse program is to describe the process for identification, assessment, and protection of residents from abuse, to be accomplished by establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment. Abuse is defined in part as a willful infliction of injury or punishment that which resulted in physical harm. Physical abuse is defined as infliction of injury on a resident other than by accidental means. Physical abuse includes but not limited to hitting, slapping and kicking. The term "willful in the definition of "abuse" means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. (B) 2 of 3 Licensure Violations	S9999		

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S9999	Continued From page 8 300.610a) 300.1210b) 300.1210d)1 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. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly	S9999		

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S9999	Continued From page 9 administered. These requirements were NOT MET as evidenced by: Based on observation, interview and record review, the facility failed provide care and services for the management of a resident's diabetes by not following physician orders to administer insulin medication as ordered, failed to document insulin administration and glucose level, and failed to have staff knowledgeable about the use of an insulin pen. These failures affected 1 of 38 residents (R6) diagnosed with diabetic mellitus receiving insulin. As a result of this failure R6 was administered 300 units of insulin and R6's blood sugar measured 205mg/dl when insulin was administered. This facility failure has the potential for R6 experiencing adverse effects and complications of unstable blood sugar including but not limited to: Diabetic ketoacidosis, Hypoglycemia and Hyperglycemia. Findings include: R6's medical record showed that R6 was admitted to the facility originally on 06/08/2020 and initial admission of 03/15/2021. Diagnosis includes but not limited to: Type 2 Diabetes Mellitus with Hyperglycemia, Type 2 Diabetes Mellitus with Diabetic Neuropathy unspecified, other seizures, Shortness of breath, Acute bronchitis, Wheezing, Chest pain, other visual disturbances, Acute Embolism and Thrombosis of unspecified Deep Veins of Right Lower Extremity.	S9999		

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S9999	Continued From page 10 R6's Minimum Data Set (MDS) dated 7/8/2022, Section C-brief interview for mental status summary score is (15) indicating R6 is cognitively intact. R6's Diabetes Mellitus plan of care with initiated date of 03/28/2021 documented interventions include but not limited to blood glucose monitoring per MD (Medical Doctor) order and document. Diabetes medication as ordered by doctor. Monitor /document for side effects and effectiveness. On 08/30/22 at 12:30pm on the 3rd floor, surveyor observed R6 sitting in a wheelchair at the nurse's station asking for V10 (LPN) to check her (R6) glucose level. V10 LPN told R6 to go and eat and that R6's blood sugar was fine. R6 stated, my (R6) glucose monitoring has not been done. V10 proceeded to obtain R6's blood glucose in view of other residents and visitors at the nurse's station despite V12 (LPN) asking V10 to take R6 to R6's room for privacy. R6's blood glucose measured 205mg/dl. V10 went to the medication cart and obtained R6's insulin pen. V10 then came back to the medication cart and obtained an insulin syringe. V10 opened the insulin syringe and inserted the insulin syringe (U100) needle into the rubber stopper of the insulin pen and withdrew insulin from the insulin pen into the insulin syringe. As V10 prepared to administer R6 the insulin at the nurses' station, V5 (SSD) came and assisted R6 to her (R6's) room and stated to V10, "Medication administration should be done in the resident's room for privacy." Upon R6 returning to her (R6) room, the surveyor observed V10 preparing to administer the insulin in R6's abdomen. Prior to V10 administering the insulin to R6, the surveyor	S9999		

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S9999	Continued From page 11	S9999		

intervened and asked V10 to clarify the dose of insulin in the syringe. V10 stated, "60 units of Humulin R." V10 showed the surveyor the syringe. The surveyor observed the insulin syringe at the 60 units measurement mark. Again, the surveyor asked V10 to clarify the amount (dose) of insulin that was supposed to be administered with the medication order since the surveyor did not observe V10 verify the physician order with the EMAR prior to preparing the insulin for administration. V10 stated, "I know the order. R6 is supposed to get 120 units but I'm given (R6) 60 units half of what is ordered." The surveyor asked V10 why she (V10) was giving R6 half of the dose of insulin ordered by the physician. V10 replied, "Personally, I don't believe R6 should be getting that much (referring to ordered insulin), so I (V10) am giving half of the dose." The surveyor asked V10 why she (V10) withdrew the insulin from the insulin pen using an insulin syringe. V10 stated, "I (V10) don't usually like the pen (referring to the insulin pen) because the insulin is usually stronger when it's used with the pen." The surveyor immediately asked V10 to stop the insulin administration and to clarify the physician order. V10 disregarded the surveyor's request and administered the insulin to R6 using the insulin syringe with the measured amount of 60 units observed on the insulin syringe. After V10 administered the insulin to R6, V10 stated to the surveyor, "I (V10) know the order."

On 8/30/2022 at 12:56pm, V10 and the surveyor checked the EMAR (electronic medication administration record) and the POS (physician's order sheet) for R6's insulin order. R6's POS dated 1/22/2022 showed an order of Humulin R U-500 K*** Pen Solution Pen-injector 500 UNIT/ML (Insulin Regular Human (Conc) to inject 140 unit subcutaneously in the morning related to

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S9999	Continued From page 12 TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65) With breakfast AND Inject 140 unit subcutaneously in the afternoon related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65) With lunch AND Inject 125 unit subcutaneously in the evening related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65) With dinner. There was no physician order to inject 60 units of insulin to R6. The order showed that R6 should have received 140 units of insulin Humulin R via insulin pen (Pen-injector). On 8/30/2022 at approximately 12:59pm, surveyor asked V10 about the facility protocol regarding insulin administration and withdrawing insulin from the insulin pen. V10 replied, "You (referring to surveyor) want the book knowledge form or what I (V10) do in real world." V10 stated, "I don't think using the pen hits the same or works well for (R6) and I'm trying to study (R6) to see what works well for (R6) so that's why." The surveyor further asked V10, what is the facility policy on medication administration regarding physician orders, notification of physician and clarification of medication orders. V10 stated, "The physician order should be carried out and medication pass should be passed one hour before and one hour after. Medication should be given as ordered by the physician." Surveyor asked V10 if she (V10) administrated R6's insulin medication as ordered. V10 replied, "No because I'm (V10) still trying to get the coverage (referring to insulin) and let the physician know about it." During this time, the surveyor did not observe V10 notify the MD of the medication error nor did V10 document notification of the medication error at the time the error was made. V10 was aware she did not administer R6 the ordered dose of insulin.	S9999		

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S9999	Continued From page 13 On 8/30/2022 at approximately 1:03pm, V2 DON (Director of Nurse's) walked out of the elevator and overheard V10 explaining V10's actions regarding insulin administration to surveyor. V2 stated to surveyor, "I can't believe the explanation of whatever question you asked her (referring to V10)." On 08/30/22 at 2:02pm V2 (DON) stated, medication is to be given as physician ordered, if it says (referring to the order) insulin pen it should be given via insulin pen. Surveyor asked V2 can the nurses change a physician order. V2 stated, "They (referring to nurses) are not physicians so they cannot change the order. All orders are to be given as physician ordered." On 8/30/22 at 2:13pm Surveyor asked V2, what can happen to residents if medication (referring to insulin) is not administered as prescribed. V2 stated, "It means the resident can go into Hypo or Hyperglycemic reaction depending on what is going on with them (referring to resident)." On 08/30/22 at 4:00pm the facility was unable to present any documentation that showed V10 informed R6's physician of the insulin medication error. MAR dated 8/30/2022 at 1730 (5:30pm) R6's BS (blood sugar) documented 182. On 09/01/22 at 11:55am, surveyor conducted interview with V25 NP (Nurse Practitioner) regarding the significance of following the physician order for insulin administration for R6. V25 stated, "R6 is non-compliant with her (R6's) diet and if the insulin is not given as ordered she (R6) may possibly have hyperglycemic or hypoglycemic episodes.	S9999		

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S9999	Continued From page 14 On 09/03/22 at 10:12am, interview with V27 (Pharmacist) regarding the amount of insulin administered to R6, and the use of an insulin syringe instead of the insulin pen. V27 stated that the amount of insulin administered to R6 via an insulin syringe equals 300 units and that is 160 units more than the 140 units ordered. V27 stated, the amount in the pen is of a large concentration 500 units/ml (Milliliters), and the way the nurse used the insulin pen defeats the purpose of how the pen was designed to be used. Facility Charge Nurse Job Description dated 2003 in part states: Purpose of Your Job Position - The primary purpose of your job position is to provide direct nursing care to the residents. Such supervision must be in accordance with current federal, state, and local standards, guidelines and regulations that govern our facility to ensure that the highest degree of quality care is maintained at all times. Delegation of Authority - As Charge Nurse you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. Duties and Responsibilities - Ensure all nursing personnel assigned to you comply with the written policies and procedures established by this facility. Periodically review department's policies, procedure manuals. Ensure that all nursing service personnel comply with the procedures set forth in the Nursing Service Procedures Manual. Perform administrative duties such as completing medical forms, reports, evaluations, studies, charting etc., as necessary. Chart nurses' notes in an informative and descriptive manner that reflects the care provided to the resident as well as the resident's response to the care. Perform routine charting duties as required and in accordance with established charting and documentation policies and procedures. Prepare	S9999		

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S9999	Continued From page 15 and administer medications as ordered by the physician. Consult with the resident's physician in providing the resident's care, etc. as necessary. Review the resident's chart for specific medication orders, etc. as necessary. Facility policy regarding Insulin Pen Usage dated 06/2021 documented in part, the policy is to provide the staff with guidance on accuracy of insulin administration and dosing. Listed responsible party are RN (Registered Nurse) or LPN (Licensed Practical Nurse). Policy statements includes but not limited to never use syringe to draw insulin out of an insulin pen cartridge. Administer insulin as ordered. Listed procedure includes but not limited to documenting each insulin dosage, site, time, in the EMAR (Electronic Medication Administration Record). The facility Medication administration policy presented with review date 11/2021 documented in part: all medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. Listed responsible party are RN (Registered Nurse) or LPN (Licensed Practical Nurse). Listed guideline includes but not limited to an order is required for administration of all medication. Checking medication administration record prior to administering medication for rights that includes the dose. Following special instruction written on the label. Document as each medication is prepared in the MAR (Medication Administration Record). If medication is not given as ordered, document the reason on the MAR and notify the Health Care Provider and resident representative if applicable. Facility presented the manufacture's undated Instructions for the use of the Humulin R U-500	S9999		

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S9999	Continued From page 16 KwikPen which included the following: Important: Know your dose of Humulin R U-500 insulin. The pen delivers your dose in insulin units. Insulin units may not be the same as syringe markings. Your Humulin R U-500 is a concentrated insulin. Do not transfer Humulin R U-500 insulin from Pen into a syringe. A severe overdose can happen, causing very low blood sugar, which may put your life in danger. Based on the evidence the facility did not follow established policies and the manufacturer's instructions for the use of an insulin pen. (B) 3 of 3 Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.	S9999		

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S9999	Continued From page 17 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were NOT MET as evidenced by: Based on interview and record review the facility failed to supervise and monitor one resident (R2) in the dining room. These failures resulted in R2 falling and sustaining a laceration to left eyebrow and suspicious complex ligamentous injury with potential cord compression. These failures have the potential to affect all 61 residents at risk for falls and all 34 smokers residing in the facility.	S9999		

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S9999	Continued From page 18 Findings include: R2's medical record documented date admission as 06/29/22, with diagnosis information that includes but not limited to unspecified Dementia without behavioral disturbances, Displaced fracture of Proximal phalanx of the left index finger, subsequent encounter for fracture and routine healing , Pain Left hand, presence of unspecified Artificial Knee Joint, Vascular Dementia without behavioral disturbance, Primary Generalized (Osteo) Arthritis, Heart Failure and Unilateral primary osteoarthritis, right knee. R2's medical record showed that R2 had a fall on 07/14/22 and was sent to a local community hospital for further evaluation and treatment. R2 was then transferred to another community hospital for further evaluation and treatment. R2's medical record dated 07/13/22 timed 2:02pm (14:02) documented that R2 is confused needs redirecting, staff gave a full body shower resident complied, skin assessed, skin intact staff will continue to monitor. R2's MDS (Minimum Data Set) dated 07/06/22 coded R2 BIMS 00 indicating that R2 is severely cognitively impaired. R2's progress note dated 7/14/2022 17:26 (5:26pm) Health Status/Progress Note Note Text: Writer (V16 - RN) observed resident in dining room and heard a noise. Writer (V16) seen resident on her left side laying on the floor. Writer (V16) assessed resident and noted open area to the left side with minor bleeding. V/S taken B/P 114/69, RR 18, pulse 73, T 98.0, SPO 98 RA. Writer (V16) and CNA (V17) help resident back in chair. Resident voiced no pain. Writer (V16)	S9999		

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asked how you fell resident stated," I was trying to get my shoes. Daughter in the building she made aware. MD called awaiting on call back.

R2's potential fall plan of care initiated 06/29/22 documented that R2 is at risk for injury from falls with goals to reduce the likelihood of the resident experiencing a fall with target date 10/12/2022.

R2's plan of care for ADL's documented that R2 has an ADL self-care performance deficit initiated 07/12/22, interventions documentation listed showed that R2 needs total assistance with staff participation with toilet use, transfer, bed mobility bathing, personal hygiene / oral care dressing and eating

On 08/24/22 at 1:48pm, V15 NP (Nurse Practitioner) was asked if she (V15) was made aware that R2 had any injury with the fall that occurred on 7/14/2022. V15 stated, "I was not notified of any injury between 8am to 6pm. I'm not on duty after 6pm. The facility nurses will have to call either the PCP (Primary Care Physician) or the NP on call. I (V15) was not notified of R2 having any injury." V15 further stated, "The facility staff are supposed to monitor and supervise the residents to prevent falls."

On 08/24/2022 at 3:39pm V17 CNA (Certified Nurse's Aide) identified herself as helping to get R2 up off the floor after R2 had a fall on 7/14/2022. V17 stated, she (V17) remembers R2 and worked on the floor the day R2 fell. V17 stated, "R2 was found on the floor in the dining area, and she (V17) was not the CNA assigned to R2. V17 stated, "She (V17) did not witness R2's fall, but the nurse told her that R2 fell". V17 stated, "She makes rounds every two to two and half hours because when they assume duty at

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S9999	Continued From page 20 3pm to 11pm shift, almost all of the residents are usually up out of the bed". V17 stated, "She (V17) helped in getting R2 off the floor and they (V16 and V17) physically lifted R2 of the floor". On 08/24/22 at 3:47pm, V18 (CNA) stated, I worked on the floor the day of the incident (7/14/2022), but I (V18) did not work with R2, and I (V18) do not remember what happened to R2 on 07/14/22. When asked how often V18 makes rounds, V18 replied, every one to one and a half hours (1 - 1 ½). On 08/24/22 at 3:52pm, V19 (CNA) was identified as working with R2 on 07/14/22 when R2 fell. V19 stated, "She (V19) was on duty but did not witness the fall and did not know where she was at the time of the fall". V19 further stated, "I (V19) do not remember the last time I saw R2 before the fall on 07/14/22. On 08/24/22 at 4:02pm, surveyor asked V2 regarding the fall with injury R2 had on 7/14/2022. V2 stated, "The facility did not get any report from the hospital about any injury. Originally R2 was sent to a local hospital and was later transferred to another local hospital". V2 stated, R2's family member wanted R2 to be sent to another hospital and then to another LTC. R2's emergency hospital record dated 7/14/2022 at 23:33 (11:33 pm) showed R2 was admitted on 07/14/22. The report documented that R2 fell at the facility, had a 3cm (Three centimeter) superficial laceration on the left eyebrow used Dermabond on the area and there was no more bleeding at the site. Under reexamination/reevaluation imaging reviewed CT head showing no acute intracranial processes. CT neck showing concerns for cord compression	S9999		

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S9999	Continued From page 21 currently. Given imaging result recommend need for emergent MRI to rule out cord compression at this time. Patient (referring to R2) will require escalation of care, spoke with (another hospital trauma center) who accepted patient (R2). Superficial laceration Dermabond shut with approximation of laceration. Diagnostic test result CT (Computer Tomography) Spine Cervical w/o contrast dated 07/14/22 at 20:48 (8:48pm) documented under impression that C1/C2/basion findings as described suspicious for complex ligamentous injury and potential cord compression. Question age-indeterminate atlantoaxial/rotatory subluxation and even low-grade occipital-axial dissociation. Recommend MRI and comparison to priors. The reason for the exam was for neck trauma. The report addendum documentation pointed out that "this report containing critical findings was discussed with (Doctor on 07/14/22 at 10:37pm). The facility Falls Management policy presented with revised date 6/21 documented in part that the facility is committed to maximizing each resident's physical, mental and psychosocial wellbeing while preventing all falls is not possible, the facility will plan for preventive strategies and facilitate as safe an environment as possible. Facility guideline following a fall incident includes but not limited to completing a fall event. This event includes the circumstances surrounding the fall devices in use, full body observation of injury, pain, range of motion and neuro checks as needed. All incident and accident with serious physical injury will be initially reported as required to the Health Department. A final written investigation is required by the Department of Public Health within seven days of incident.	S9999		

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