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
	IL6008890	A. BUILDING: ______ B. WING ______	C 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CLARA'S REHAB & SENIOR CARE	1450 CASTLE MANOR DRIVE LINCOLN, IL 62656

(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 Facility Reported Incident Investigation to incident of 7/7/22/IL149145	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.690a) 300.1010h) 300.1010i) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)2) 300.3240a) 300.3240b) 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	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures. 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	S9999		

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S9999	Continued From page 2 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. Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.3240 Abuse and Neglect	S9999		

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S9999	Continued From page 3 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) These Requirements were not met evidenced by: Based on observation, interview, and record review, the facility neglected to provide R1 with a thorough assessment, medical assistance, pain control and pain assessment, and timely treatment of a fracture resulting from a fall for one of three residents (R1) reviewed for neglect in the sample of three. These failures resulted in R1 being left in excruciating pain from an acute left hip fracture, without Physician or power of attorney notification or treatment for over ten hours following the fall, and R1 being forced by staff to transfer between surfaces two different times while sweating and yelling out in pain and guarding the left hip, while staff refused R1's requests to be sent to the emergency room due to R1 knowing he had a left hip fracture and pain. Findings include: Resident Care Policy and Procedure Regarding Abuse and Neglect, Involuntary Seclusion, Exploitation, Misappropriation of Resident Property, Injuries of Unknown Origin, and Social Media policy dated 3-15-18 documents," Subject: Abuse prohibition. Abuse and Neglect is	S9999		

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S9999	Continued From page 4 prohibited. All residents have the right to be free from verbal, sexual, physical, mental abuse, corporal punishment, involuntary seclusion, neglect, misappropriation of property, and exploitation. An owner, licensee, administrator, employee, or agent of a facility shall not abuse or neglect a resident. Neglect means a failure in a facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress." The facility's Management of Pain policy dated 4-4-12 documents, "Policy: Our mission is to facilitate resident independence, promote resident comfort, and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. We will achieve these goals through: Promptly and accurately assessing and diagnosing pain. A standard format for assessing, monitoring, and documenting pain in both cognitively intact and cognitively impaired residents will be utilized. As part of a comprehensive approach to pain assessment and management, pain will be considered the fifth vital sign of the facility. For purposes of this policy, pain is defined as 'whatever the experiencing person says it is, existing whenever the experiencing person say it does.' Procedure: Physician Communication and Involvement-Pain will be assessed and managed in a timely fashion, especially if it is of recent onset. The Physician will be notified of resident's complaint of pain when not relieved by medication as ordered by the Physician. Thorough communication with the Physician will ensure an	S9999		

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S9999	Continued From page 5 appropriate pain management plan. Nursing Involvement: Pain Screening-Upon change in condition or when new pain or an exacerbation of pain is suspected, the Pain Questionnaire will be filled out with input from the resident, family member, or responsible party. If the resident scores a five or above on the Pain Questionnaire, the Comprehensive Pain Assessment must be completed. Comprehensive Pain Assessment measures the impact of pain on the resident's function, assessing the resident's physical condition, history, mental status, and ADLs (Activities of Daily Living). The assessment will cover the following areas: intensity, location, onset, type, frequency, description, change, treatment, effect, and what makes it better or worse. A licensed nurse will initiate the Comprehensive Pain Assessment under the following circumstances: A change in resident condition occurs to requires pain control and new pain is reported. Nursing Observation is an important part of the pain assessment, especially in the non-verbal resident. Using the chart provided with the pain assessment, nursing will observe behaviors that may indicate pain in the non-verbal or cognitively impaired resident. Pain may be indicated when there are changes in the following: Facial expression, vocal behaviors, body movements, routines, mental status. Physical Examination: The nurse will complete a physical evaluation of the resident that include the following: Vitals, bowel sounds, lung sounds, and objective observation of the painful area. Plan of Care-Initiate an interdisciplinary plan of care based on the initial assessment, the choice of a pain rating scale, and the development of pain-relieving strategies. Include both pharmacological and complementary interventions in the care plan. An immediate care plan will be initiated upon admission for any	S9999		

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resident with orders for pain management, with reports of pain/injury or exhibiting common pain behaviors and reviewed at each care plan conference. Pain flow sheet-Initiate a pain flow sheet for all resident reporting pain regardless of the treatment. The pain flow sheet is completed each shift. The effectiveness of pain interventions should be measured one to two hours after administration of treatment using the pain scale chosen by the resident or the behavioral indicators. Documentation-Document interventions and responses in the medical record as appropriate and on the pain flow sheet."

The facility's Fall Assessment and Management policy dated 04-2019 documents, "It is the policy of this facility to assess each resident's fall risk on admission, quarterly, and with each fall. This will help facilitate an interdisciplinary approach for care planning to appropriately monitor, assess and ultimately reduce injury risk. Factors related to the risk will be addressed and care planned. Post fall assessment-immediately after fall: After a fall, the resident will not be moved from their position until a licensed nurse determines it is safe to do so. A licensed nurse will immediately assess the resident after a fall. Assessment parameters may include level of consciousness, complaints of pain, decreased range of motion, vital signs, and presence or absence of obvious injuries (lacerations, bruises, obvious fractures, bleeding, etc.) Assessment parameters also may include: A description of how the resident was observed and circumstances surrounding the fall, such as what the resident was doing at the time. Unusual signs or symptoms. The Physician will be notified immediately when an accident involving a resident, results in injury and has the potential for requiring Physician intervention. The responsible party will be notified promptly."

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The facility's Guidelines for Physician Notification of Change in Resident Condition policy dated 04/2019 documents, "Purpose: To define resident care situations that require Physician notification. Change in condition may include Redness or swelling of any body part, newly defined deformity of any body part, new or increased complaints of pain, and accidents or occurrences. CNAs (Certified Nursing Assistants) are responsible for reporting any changes they observe to their charge nurse. It is the responsibility of each nurse to notify the Physician of a significant change in condition before the end of the shift."

R1's Admission Face Sheet dated 6-26-20 documents R1 is a 67-year-old with the diagnoses of Parkinson's Disease, Dementia without behavioral disturbance, Major Depressive Disorder, Muscle Wasting and Atrophy, Anxiety Disorder, Chronic Pain, and Hypotension.

R1's Annual MDS (Minimum Data Set) Assessment dated 6-28-22 documents R1 is cognitively intact, exhibits no behaviors, has had no pain, and has had no falls since the prior MDS assessment on 3-31-22. This same MDS assessment documents R1 requires a walker for mobility and supervision of one staff physical assistance for transfers and walking on/off the corridor and in his room.

R1's Progress Notes dated 7-7-22 at 8:15 PM and signed by V3 (LPN/Licensed Practical Nurse) document, "(R1) states to staff that he fell in the hallway going towards the cafe area. (R1) has told four different stories to five different staff members. (R1) was seen up walking down hallway after he stated that he fell. (R1) states

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that he has broken his right hip and then stated that he broke his left hip. (R1) was able to stand and pivot without difficulties. There is no external rotation to either leg."

R1's Medical Record does not include any further documentation regarding R1's fall, an assessment of R1's verbalization of having a left hip fracture and pain, a comprehensive pain assessment, Physician notification regarding R1's complaints of injury to the left hip, or power of attorney notification of R1's complaints of injury to the left hip after the Progress Note entered by V3 on 7-7-22 at 8:15 PM, until 7-8-22 at 6:15 AM when V5 (LPN) documented regarding R1's fall.

R1's Progress Notes dated 7-8-22 at 6:15 AM and signed by V5 (LPN) document, "After receiving report from night nurse (V3 LPN), this nurse went to (R1's) room to assess (R1). Upon entering (R1's) room, nurse observed (R1) laying on right side of body while aides were performing care on (R1). Nurse observed (R1) yelling out in pain at slightest movement in body when aides attempted to reposition (R1). Nurse had aides reposition (R1) on to his back to perform assessment. Nurse palpated left hip area due to (R1's) complaint of pain in that area. (R1) yelled out in pain. (R1) unable to lift left leg. Unable to perform flexion/extension motion or rotate left foot outward or inward. Nurse also observed (R1) sweating profusely. (R1) informed nurse pain level at 10. VS (Vital Signs) BP (Blood Pressure) 149/84, Pulse 104, Oxygen Saturation at 96 percent at room air, temperature 99.1 (degrees Fahrenheit), respirations 20."

R1's Progress Notes dated 7-8-22 at 6:55 AM and signed by V5 document, "At 6:20 AM (R1) informed nurse of unwitnessed fall on 07/07/2022

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S9999	Continued From page 9 near cafe area by entrance/exit doors. (R1) informed nurse he fell on tile flooring. Complaint of left hip pain. (R1) cried out in pain to touch and when aides attempted to change his depends. (R1) requested to be sent to emergency room. 6:42 AM: 911 called. 6:53 AM: (R1) transported to (Local Hospital) emergency room via stretcher. 6:53 AM: Power of attorney called. Left voicemail. Awaiting call back. 7:01 AM: manager on call notified." R1's Hospital Clinical Report dated 7-8-22 at 7:04 AM documents, "Chief complaint: Injury to left hip. The injury happened last night. (R1) presents to the emergency room with complaints of left hip pain after he fell last night. (R1) states he had his walker but slipped on something on the ground when he was walking, causing him to fall. (R1) states he landed on his left hip. (R1) states he was unable to put weight on that hip, so they had to get him into a wheelchair. However, they (the facility staff) did not send him over for evaluation until this morning when he told the staff he was having a lot of hip pain. Physical Exam: Left hip: deformity and mild tenderness. The left leg is shortened. Significant pain when moving (R1) around. Updated (R1) on results of x-ray and that he broke his hip. Discussed need to be transferred out of this hospital for surgery." R1's Left Hip Radiology Report dated 7-8-22 documents, "Findings: There is an acute impacted fracture of the mid-left neck (left hip) without significant displacement or angulation." R1's Surgical Report dated 7-9-22 documents R1 required a surgical hemiarthroplasty (replacement of half of the hip joint/screw fixation of the left hip to repair R1's left hip fracture.	S9999		

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S9999	Continued From page 10 R1's Care Plan dated 7-12-22 does not include a pain plan of care with interventions to treat R1's pain sustained after the fracture on 7-7-22. V3's (LPN) Disciplinary Action Form dated 7-11-22 and signed by V3 and V2 (Director of Nursing/DON) document, "Type of Documentation: Written. Type of Violation: Unsatisfactory job performance, or substandard quality or quantity of work. Description of Violation: Failed to follow fall policy when a resident (R1) self-reported a fall to her." V3's (LPN) Disciplinary Action Form dated 7-15-22 and signed by V3 and V2 (Director of Nursing) documents, "Type of Documentation: Last Chance. Type of Violation: Violation of established safety rules or standard operating procedures, including failure to report personal injuries or resident injuries in a timely manner. Description of Violation: Failed to notify the Physician of a change in condition of a resident (R1)." V9's (CNA) Disciplinary Action Form dated 7-15-22 and signed by V9 and V2 documents, "Type of Documentation: Last Chance. Type of Violation: Violation of established safety rules or standard operating procedures, including failure to report personal injuries or resident injuries in a timely manner. Description of Violation: Failure to contact supervisor regarding a resident (R1) that she felt needed to be sent to the emergency room and the nurse (V3) was not taking action." V4's (CNA) Disciplinary Action Form dated 7-15-22 and signed by V4 and V2 documents, "Type of Documentation: Last Chance. Type of Violation: Violation of established safety rules or standard operating procedures, including failure	S9999		

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to report personal injuries or resident (R1) injuries in a timely manner. Unsatisfactory job performance, or substandard quality or quantity of work. Description of Violation: Failed to contact supervisor regarding a resident (R1) that she felt needed to be sent to the emergency room and the nurse (V3) was not taking action. Failed to follow fall protocol, transferring a resident, that self-reported a fall, before the nurse had examined him."

V5's (LPN) undated written statement documents, "(Around 6:00 am 7-8-22) Received report from the night nurse (V3 LPN) that (R1) has been ringing call light and yelling all night. Per night nurse, (R1) complaining of left hip pain due to fall on 7-7-22."

V6's (CNA) undated written statement documents, "On Thursday 7-7-22, I was working on rehab (rehabilitation hallway) 6:00 PM-10:00 PM. (V11/LPN) was the nurse on rehab. Several visitors and other employees came over to rehab to let us know that a resident (R1) is sitting in a chair by the doors saying he fell and needs an ambulance. After the second person came to tell us, I decided to go down there to see what was going on. When I walked down to the seating area by the doors, I saw (R1) sitting there. I asked what happened and (R1) said he fell on the curve of birch/oak in front of the plants, and then said he used his walker as a crutch to get off the floor and walked to the seating area. (R1) then asked me to call an ambulance. (R1) was clearly in pain and was sweating. I went to go talk with the nurse and other CNAs on birch/oak (hallways) about (R1) to see what was going on, and they said (R1) was having a behavior and the CNAs said the nurse (V3 LPN) told them to leave (R1) there until his behavior issues are over. After

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S9999	Continued From page 12 that, I went back to my hall. The nurse for rehab (V11) went on break and when she came back, she told me that (R1) was still there asking for an ambulance." V7's (CNA) undated written statement documents V7 was working 2:00 PM to 10:00 PM on 7-7-22 and witnessed R1 sitting in a wheelchair in front of the nurse's desk, sweating like he was in pain, however everyone (facility) staff was saying R1 was fine, and it was behavioral. V8's undated interview with V2 (Director of Nursing) documents, "On 7-7-22 at 8:15 PM, (R1) was sitting in a chair up at the front saying that he does not know what he did and that he could not move because he broke his hip. (V8) said she got (R1) a wheelchair, transferred (R1) to the chair, and took him to the nurse (V3). The nurse told (V8) that (R1) does that all the time." V9's (CNA) written statement dated 7-8-22 documents, "At 8:00 PM (7-7-22) I walked down to birch/oak (hallways) to get fingernail clippers for my resident on maple/walnut (hallways). On my way, I saw (R1) sitting in a blue sofa chair by (V2's/Director of Nursing) office. (R1) said he needs help and needs to go to the hospital. I asked the girls on birch/oak what was going on with (R1) and they said (R1) won't get out of the chair and needs to get back up but is saying he won't unless it is by a stretcher. (V8 and V4/CNAs) were on their way down to get (R1) with a wheelchair. I walked over 15 to 30 minutes later, and they were trying to get (R1) to stand by talking to (R1). (R1) had told me when I originally walked by that he had fallen. The fall was unseen. I was told (R1) had stood and walked, however I did not see him stand or walk. At 10:15 PM, the nurse (V3) told me and (V4 CNA)	S9999		

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S9999	Continued From page 13 that we need to get (R1) into bed. We changed (R1) and (V3) assessed him. When we finished changing (R1), I told both of them (V3 LPN and V4 CNA) that they should send (R1) out in case something did actually happen." V12's (CNA) written statement dated 7-11-22 documents, "It was 8:01 PM when I and (V4) came back in from our lunch break where we had found (R1) sitting in the foyer in front of birch/oak entrance. We proceed to stop and ask (R1) how he was, and he responded by saying not very good, I need some help. I came to the left side of the chair noticing the left side of (R1's) pants was off his hip, seeing an old scar. I then asked him what was wrong, and he told me he had (fallen) coming from around the corner of birch/oak (hallways) where he proceeded to use the railing on the wall to get himself up from the floor and came to the foyer and sat, and that it where he had been until we had showed up." V13's (CNA) written statement dated 7-8-22 documents, "I received report from (V9/CNA). (V9) stated that (R1) at the beginning of the shift stated that he fell and fractured his hip. (V9) informed me that (R1) had been hollering all night and pushing his call light. His light was ringing when I arrived (6:00 am). We proceeded in to tend to his light, I walked into a brown ring underneath (R1) with a soaked (adult brief) and soaked shirt." On 7-22-22 at 9:15 AM, R1 was lying in bed. R1 had a gauze dressing to his left hip. R1 stated, "On 7-7-22 around 7:30 PM, I fell going around the corner from this hallway towards the administration offices. I had my walker and it got caught when I lost my balance and fell. I just went down and landed on my left hip. My hip hurt	S9999		

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S9999	Continued From page 14 so bad. No staff was around, so I was able to get myself up and I wobbled about 60 feet to a chair in the front lobby. Staff did not find me until 8:00 PM. The nurse that night (V3/Licensed Practical Nurse/LPN) made me sit in the chair and would not send me to the emergency room. I kept telling her I wanted to go to the emergency room. I knew my left hip was broke. The nurse had staff put me in a wheelchair about two hours later. I could not even stand. The staff lifted me under my arms and put me in a wheelchair. It hurt so bad. I was crying and screaming in pain. The staff wheeled me to an area by the desk and left me there for hours. The nurse never did ask me if I needed anything for pain. I kept telling every staff member that walked by that I needed to go to the emergency room, but no one would listen. Later on, the nurse made me go to my room and get into bed. I was still screaming in pain. The staff picked me up again and slammed me into my bed. It hurt so bad. I suffered until the next morning. No one did anything for me, until the next morning. The morning nurse came in and sent me straight to the hospital. I was sent to another hospital and had to have surgery on my left hip. The morning nurse was my guardian angel. I have never felt so neglected in my life and that night nurse should not be taking care of anyone." On 7-22-22 at 9:32 AM V3 (LPN) stated, "On 7-7-22 around 8:00 PM, a CNA came and got me and said that (R1) had fallen. (R1) was sitting in the lobby in a chair. I did range of motion with (R1), and it was fine. I do not recall all of the events the rest of that night. I was too busy. I know (R1) was on his call light all night saying his hip was broken. (R1) has behaviors. I did not call the doctor and report (R1's) fall. I let the day shift nurse know when she came on shift around	S9999		

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6:00 AM. (V5/LPN) sent (R1) right to the emergency room and (R1) had a broken hip."

On 7-22-22 at 10:00 AM V4 (CNA/Certified Nursing Assistant) stated, "I came in from my lunch break around 8:02 PM and saw (R1) sitting on the chair in the front lobby. (R1) told me he had fallen. (R1) said he was walking around the corner, off of the unit, lost his balance and fell. I went to tell the nurse (V3 LPN) that (R1) fell. (V3) yelled at me, 'I do not have time for this tonight. I feel like calling (V10/Scheduler/CNA) and telling her I need to go home.' I then saw his CNA (V8) coming up the hallway and told her (R1) needed vital signs and had fallen. Me, (V3 LPN) and (V8 CNA) then went back up to the lobby where (R1) was sitting. (R1) told us he needed to go to the emergency room. (V3) told us to transfer (R1) into the wheelchair and take him into his room. Me and (V8) tried to stand (R1) to get him to transfer to the wheelchair. (R1) started screaming he needed to go to the hospital and wanted us to call 911. (R1) said the only way he was leaving that chair was on a stretcher. (V8) said, 'I am not doing this.' We sat (R1) back down in the chair and (V8) went back to the unit (V8) was working on. I left (R1) in the chair in the lobby and went and told (V3 LPN) that (R1) could not transfer to the wheelchair because he was in too much pain. (V3) continued to pass medications to other residents and said to leave (R1) in the chair. A little later, (V6/CNA) from a different hallway came over and told us that (R1) had told her he had fallen and needs to go to the hospital. (V8) told (V6) that she already knows (R1) fell. (V8) said to me, 'I am tired of staff coming over here telling us about (R1). Let's go get him up into the wheelchair.' Me and (V8) went back up to the lobby where (R1) was sitting. (V8) told (R1) he had to get up in the wheelchair

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S9999	Continued From page 16 because the EMTs (Emergency Medical Technicians) could not get him in the front lobby and (V3) needed to examine him in his room. (R1) agreed to get in the wheelchair when (V8) told him EMTs could not pick him up in the lobby. Me and (V8) lifted (R1) from the chair to the wheelchair. (R1) could not bear weight on his left leg and was yelling out in pain during the transfer. (R1) could not pick up his left leg, so I placed his left foot on top of his right foot, turned his wheelchair backwards, and (V8) wheeled him to the nurse's station. Nobody had examined him yet. It was shift change and I was trying to finish charting. (R1) continued to moan. (R1) sat in the wheelchair for a long time, while (V3) finished her medication pass and treatments. (V3) then told me and (V9/CNA), we all need to get (R1) into bed. I wheeled (R1) backwards in the chair again to his room. (V3 and V9) lifted (R1) from his wheelchair into his bed. While transferring, (R1) was screaming, 'Wait. Wait. Wait.' (R1) was sitting on the side of the bed. (V3 and V9) went to grab (R1's) legs to lift them up into the bed and noticed (R1's adult brief) was wet and soiled. (V9) made (R1) turn from side to side to change his (adult brief). (R1) was screaming in pain and was trying to get (V9) to stop. (V9 CNA) said, '(R1) is too much!' (V9) continued to pull (R1's) brief down. (R1's) left hip was bulging and there was obviously something wrong with it. I told (V3 LPN) to look at (R1's) left hip. (V3) never did look at (R1's) hip. We positioned (R1) in bed and left the room. I could hear (R1) screaming out in pain clear up the hallway. (V9 CNA) complained about (R1) the entire night. (R1) was left in his room, in pain, until the next morning around 6:00 AM when another nurse came in and sent (R1) to the emergency room. (R1) was definitely neglected. Last Friday, (7-15-22), (V1/Administrator) and (V2/Director of Nursing) gave me a write-up	S9999		

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S9999	Continued From page 17	S9999		

because I did not call my supervisor to let them know that I did not think (V3 LPN) was taking adequate care of (R1) after (R1) fell."

On 7-22-22 at 10:45 AM V5 (LPN) stated, "I came in at 6:00 AM on 7-8-22. (R1) told me he had fell on the tile by the lobby the night before and was able to get himself up and walk to the chair in the lobby. (R1) was in a lot of pain and had a lump on his left hip. (R1) said he was in pain all night and had told the night staff he wanted to go to the hospital because he thought he had broken something. I immediately sent him to the emergency room. Later that day, (V2 Director of Nursing) had called the hospital and got report. The hospital told (V2) that (R1's) left hip was fractured."

On 7-22-22 at 11:25 AM V6 (CNA) stated, "I was working a different hallway on 7-7-22 from 6:00 PM to 10:00 PM. I saw (R1) in the lobby sitting in a chair around 8:15 PM. (R1) said he had fell and was waiting on an ambulance. (R1) was sitting crooked in the chair and was very sweaty. I went and told (V8 CNA) that (R1) said he had fell and was in pain. (V8) told me (V3 LPN) had said (R1) needs to sit there until his behavior stops. A little later, (R1) was sitting in a wheelchair and was sweaty from head to toe and requesting to get an ambulance. I knew something was wrong with (R1) because (R1) never wants to go to the hospital. (R1) was definitely in pain. (R1) would not yell out in pain unless he was hurting really bad. (V4 CNA) came over to my hallway a little later and told me (R1) had been sitting in pain for over two hours and (V3) still had not assessed him. I left at 10:00 PM that night and do not know what happened after that."

On 7-22-22 at 12:00 PM V7 (CNA) stated, "On

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7-7-22 at 8:45 PM, I was sitting at the nurse's desk and (R1) was sitting in a wheelchair in front of the desk. (R1) was sweating a lot and saying he was in pain. (R1) kept repeating he needed to go to the emergency room because he fell, and his hip was hurting. (V3 LPN) never did assess him while I was there. (V3) kept saying (R1) was having behaviors. I have never seen (R1) have behaviors like that. I know (R1) was in a lot of pain."

On 7-22-22 at 12:30 PM, V2 (Director of Nursing) stated, "(V3 LPN) was disciplined because she did not call or report to (R1's) physician or (R1's) power of attorney after (R1) fell and was complaining of pain on 7-7-22. (V3) did not do a thorough fall assessment or pain assessment and should have. (V4 CNA) and (V9 CNA) were disciplined because they did not report to their supervisor when they felt like (R1) was not getting the cares he needed, and felt like (V3) should have sent (R1) to the emergency room for complaints of pain and a hip fracture and (V3) refused to send (R1) in."

On 7-23-22 at 6:20 PM V11 (LPN) stated, "I worked 6:00 PM to 6:00 AM on 7-7-22 through 7-8-22. On 7-7-22 around 8:15 PM me and (V6 CNA) went up to the front lobby to check on (R1). (R1) was sitting in a chair and said he had fallen and broke his hip. (R1) said he needed an ambulance. (V6) went and told (V3) that (R1) was in a chair and was saying he broke his hip and needed and ambulance. (V3) told (V6) that (R1) did not fall and (R1) was just having a behavior. Later on, I was coming in from my lunch break around 1:30 AM, and (V3) was outside. (V3) said (R1) is still having behaviors and has been screaming all night. Around 5:00 AM, (V9/CNA) came over to my hallway to see

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her dad who is also a resident at the facility. (V9) said to me (R1) has been up screaming all night and on his call light. (V9) said (V3) told her to just let (R1's) call light go off. (V13/CNA) came into work at 6:00 AM that morning (7-8-22) and was (R1's) CNA. (V13) told me when she came in (R1) was screaming bloody murder in pain and was grabbing his left hip saying it was broken."

On 7-23-22 at 8:30 PM V8 (CNA) stated, "(V4 CNA) came and got me and said (R1) had fallen and was sitting up in a chair in the lobby. I went and told (V3 LPN) and she said to check his vital signs. (R1) said he could not move and could not get up. (R1) said something about his left hip. I told (V3) that (R1) was unable to move, or get up, and she said to transfer him into a wheelchair. Me and (V4) had to pick (R1) up under the arms and transfer him to a wheelchair. (R1) was unable to pick his left leg up so I had to wheel his wheelchair backwards. I wheeled him in front of the nurse's desk. (R1) was shaking and saying he could not move. (V3 LPN) kept saying (R1) was just having behaviors. I was off work at 10:00 PM and did not see (R1) after that."

On 7-24-22 at 7:30 AM, V12 (CNA) stated, "Me and (V4 CNA) came in from break on 7-7-22 around 8:01 PM and found (R1) sitting in a chair in the lobby. (R1) said he had fallen, gotten himself back up, and walked to the chair. (R1) had his pants pulled down on the left side and said he was in pain, his left hip hurt, and he needed an ambulance. (V4) was his CNA that night and went to get (R1's) nurse. I did not take care of (R1) the rest of the night."

On 7-25-22 at 7:30 AM V13 (CNA) stated, "I came in at 6:00 AM on 7-8-22 and (R1) had his call light was on. I answered the call light and

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S9999	Continued From page 20 (R1) was yelling 'bloody murder' in pain. (R1) was soaked in urine and there was a brown urine ring under (R1). (R1) was drenched in sweat and you could tell (R1) was in excruciating pain. I asked (V9/CNA) why (R1) was soaked in urine and (V9) said they thought (R1) could change himself. (V9) also reported to me that (R1) had been on his call light screaming all night and the nurse (V3) told (V9) to just shut the call light off. The day shift nurse (V5 LPN) came in and assessed him and knew (R1) was in pain and broke his hip. (V5) sent him to the emergency room." (A)	S9999		