STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009815	A. BUILDING: _____ B. WING _____	C 11/14/2022

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APERION CARE FAIRFIELD	305 N.W. 11TH STREET FAIRFIELD, IL 62837

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S 000	Initial Comments Complaint Investigation #2258327/IL152383 Complaint Investigation #2258264/IL152317	S 000		
S9999	Final Observations	S9999		

1/3

Statement of Licensure Violations:
300.610a)
3001210b)4)

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.
4) All nursing personnel shall assist and

Attachment A
Statement of Licensure Violations

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S9999	Continued From page 1 encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. These regulations were not met as evidenced by Based on observation, interview, and record review the facility failed to ensure call lights were answered timely for 6 of 6 (R5, R6, R7, R8, and R9, R20) residents reviewed for resident rights in the sample of 20. This failure resulted in the following 1. R5, who had a history of a brain bleed, was laying on the floor for four hours before being found by facility staff. 2. R9 who has a history of pressure ulcers and is being up in his chair for more than two hours, sitting in urine that burns his skin, and being in pain. 3. R6 who had recently had a catheter removed did not recieve timely bladder training and had to do bladder training herself in her adult incontinent brief since it took facility staff too long to respond to the call light. This has the potential to affect all 67 residents residing in the facility. Findings Include: 1. R5's facility Admission Record with a print date of 10/20/2022 documents R5 was admitted to the facility on 10/07/22 with diagnoses that include chronic kidney disease, cardiac arrythmia, dependence on renal dialysis, type 2 diabetes, morbid obesity, atrial fibrillation, and person	S9999		

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S9999	Continued From page 2 injured in unspecified vehicle accident. R5's MDS (Minimum Data Set) dated 10/08/22 documents a BIMS (Brief Interview for Mental Status) score of 15, which indicates R5 is cognitively intact. Section G of R5's MDS documents R5 requires two-person physical assist for transfers and one-person physical assist for bed mobility. R5's undated care plan documents a Focus area date initiated 10/08/22 of "I am at (Specify High, Moderate, Low) risk for falls r/t (related to). Goal: I will not sustain serious injury through the review date. Date initiated: 10/08/2022, Target Date: 01/06/2023, Interventions/Tasks: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt responses to all requests for assistance. Date initiated 10/08/2022." R5's progress notes document on 10/12/2022 7:30 AM that R5 had an un-witnessed fall at 6:30 AM in his room when he attempted to arise from his recliner to take himself to bed. The note documents that R5 slid from his recliner to the floor, stated no injuries were obtained. The progress note also documents R5 was alert and oriented to time, person, place, and situation. No injuries observed. The note further documents the following intervention: "re-educate resident frequently to use call light, assure call light and cell phone is within reach at all times." The facility Concern/Compliment Form dated 10/13/2022 documents under Nature of Concern/Compliment, "R5 stated that he slid out of his recliner into the floor. Resident (R5) stated he doesn't know what happened or how long he	S9999		

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had been there. Stated he has moments where "he forgets." Under Summary of Pertinent Findings, the report documents, "After investigating incident, resident was found to be in floor for only a short amount of time. No injuries noted." Under Corrective Actions Taken: "Staff educated on timely call light monitoring."

On 10/18/22 at 4:00 PM, V5 (Family Member) stated she was informed by a family member that R5 had reported to them he ended up in the floor around 2:00 AM and that R5 had pushed the call light multiple times and hollered for help, but no one came until around 6:30 AM to assist him.

R5's local hospital emergency room record dated 10/12/22 documents R5 was evaluated at the local hospital at 2:33 PM for a fall. Under Assessment R5's hospital Nurse's Notes documents, " Patient brought to ER (emergency room) from (name of facility) by family member who reports patient fell at nursing home this morning. Patient was in floor for approx. (approximately) 4 hrs (hours) and is unsure if he slid off the bed or had stood up and fell. Patient is slightly confused and family states that patient has been declining cognitively since Sunday."

On 10/19/22 at 9:32 AM, R5 was alert and oriented and asked about his fall on 10/12/22. R5 stated he was sitting in his chair in his room and must have dozed off. R5 stated when he woke up, he had slid down the front of his chair and couldn't get back up. R5 stated he tried to find the call light but couldn't find it at first. R5 stated he hollered out several times. R5 stated he then found the call light and pushed it around 2:00 AM. R5 stated the facility staff finally came in after 6:00 AM and got him up and took him to the bathroom. R5 stated he pulled the chain in the

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bathroom, and no one came back. R5 stated he would tell staff he needed something, and they wouldn't come back. When asked how he knew how long he was laying in the floor the morning of his fall, R5 stated because he could see the clock on the wall. R5 stated at some point he ended up with his head on the floor under the table next to his bed in his room. On 10/27/22 at 10:39 AM, surveyor observed the room where R5 resided while at the facility. The beds in the room were facing a wall with a clock in the center of that wall. A recliner was beside one of the beds also facing the wall with the clock. The clock was noted to have accurate time displayed.

On 10/18/22 at 12:58 PM, V6 (CNA/Certified Nursing Assistant) stated R5's call light was on when she came to work on 10/12/22 at 6:00 AM. V6 stated V8 (CNA) went into R5's room and found R5 on the floor. V6 stated she didn't provide care to R5 that day.

On 10/18/22 at 3:00 PM, V8 (CNA) stated R5's call light was on when she got to work on 10/12/22. V8 stated she answered a different residents call light first and provided care to that person then went to R5's room. V8 stated when she entered R5's room she saw him on the floor in front of his recliner with his head in front of his recliner. V8 stated R5 appeared to have missed his chair when sitting down. V8 stated she immediately went to get the nurse to assess R5. V8 stated R5 reported to them he had been laying there for hours and had been calling for help.

On 10/21/22 at 12:02 PM, V20 (LPN/Licensed Practical Nurse) stated she was working on 10/12/22 when R5 fell. V20 stated the CNA told her he had fallen. V20 stated it was after she had given report to the oncoming day shift. V20 stated

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it appeared as if R5 had fallen out of his recliner. V20 stated she couldn't remember if R5's call light was on at that time, but she knew it wasn't on when she was on that hall around 4:30 or 5:00 AM. V20 stated she was pretty sure R5 had received medications on the morning of 10/12/22. V20 stated she wasn't sure, but she knew she was in the room next to R5's that morning and had a conversation with the CNA's in the hallway right outside R5's room. R5's Medication Administration Record (MAR) dated 10/1/22 to 10/31/22 has no documentation showing any medications were administered on the morning of 10/12/22.

On 10/26/22 at 10:30 PM, V21 (CNA) stated she took care of R5 on the night of 10/11/22 into the morning of 10/12/22. V21 stated she couldn't remember if R5 used his call light on the night of 10/11/22 or the morning of 10/12/22. V21 stated she couldn't remember when exactly they were in R5's room that night but she checks on every resident every couple of hours.

On 10/26/22 at 10:24 PM and 10:40 PM, V22 (CNA) stated she provided care to R5 on 10/11/22 into the morning of 10/12/22. V22 stated she was in R5's room around 8:30 PM or 9:00 PM and then again at 2:00 AM and 4:00 AM. V22 stated she didn't remember if R5's call light was on at any time through the night. V22 stated it takes approximately 3 minutes to answer the lights and she hasn't had any residents complain call lights aren't being answered timely. When asked if she was involved with R5's care when he fell on the morning of 10/12/22, V22 stated she was probably giving report. When asked how they give report, V22 stated they do rounds. When asked to explain what that means, V22 stated they go to each room and tell the oncoming shift

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what happened with the resident through the night. When asked if she remembered doing rounds on the morning of 10/12/22, V22 stated they try to do them every morning. When asked if she saw R5 when she was doing rounds on the morning of 10/12/22, V22 stated, "No, he was probably already up."

On 10/27/22 at 10:52 AM, V6 (CNA) stated she got report at the nurse's station on the morning of 10/12/22. When asked if they did rounds and saw each resident, V6 stated they did not. When asked if anyone reported R5 falling V6 stated, "No."

On 10/26/22 at 9:41 AM, V1 (Administrator) stated R5 couldn't have been in the floor from 2AM to 6AM like R5 said. V1 stated he knew R5 didn't have his call light on because R5 said it was in his hand and then he said it slid out of his hand and the video shows people walking up and down the hallway. When this surveyor asked to view the video, V1 asked if it would help his case. This surveyor stated she was unsure due to not having seen the video yet.

On 10/27/22 at 2:15 PM, this surveyor observed the video of R5's hall on 10/12/22 with V1 and V2 (DON/Director of Nurses) present. The door to R5's room was not clearly visible as the camera was facing the opposite wall and there was something obstructing the direct view of R5's doorway. At 5:48 AM, there was a CNA (possibly V21) who entered the hallway and got linens off the cart in the hallway. V21 then entered either R5's room or the room next to it. V21 then exited the room with dirty linens and placed them in a receptacle. On this same date and time, V2 stated R5 had been incontinent. R5's nurses notes reviewed from 10/07/22 to 10/13/22

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document R5 is continent of bowel and bladder. V1 (Administrator) walked down the hall on live video to show this surveyor V21 entered R5's room. It was not clear on the live camera feed, which room V1 was entering. Based on the view available from the video, it was not possible to determine if V21 entered R5's room or the room next to it.

2. R9's facility Admission Record with a print date of 10/26/22 documents R9 was admitted to the facility on 9/8/22 with diagnoses that include unspecified wound left foot, paraplegia, osteomyelitis, hypertension, and insomnia.

R9's MDS dated 9/15/22 documents a BIMS score of 13, which indicates R9 is cognitively intact. Under Section G of this same MDS, R9 is documented as requiring assist of two staff for transfers and toileting.

R9's undated and incomplete care plan documents a Focus area of "I have an ADL (activities of daily living) self-care performance deficit r/t (related to)" Interventions included are, " Bed Mobility: The resident requires (Specify what assistance) by (X) staff to turn and reposition in bed (specify frequency) and as necessary toilet use: The resident requires (Specify assistance) by (X) staff for toileting, transfer: The resident requires Mechanical Lift (specify) with (x) staff assistance for transfers." R9's care plan documents a Focus area of "I have diabetic ulcer of the (specify location) r/t" with interventions that include, "Position resident off affected area. Change position every 2 hours and PRN (as needed)."

On 10/18/22 at 3:00 PM, V8 stated she has told R9 he could talk with V2 (DON) about call light

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complaints. V8 stated she left a note in V2's office addressed to the Director of Nurses and Administrator for R9.

On 11/03/22 at 1:04 PM V2 (DON/Director of Nurses) stated she knew she had gotten notes and/or verbal updates related to R9, but she couldn't remember a specific note related to call lights.

On 10/27/22 at 3:00 PM, R9 was observed sitting in his motorized wheelchair in the hallway. R9 entered his room and stated he had been waiting to go to bed for two hours. R9 stated staff come and turn his call light off and then he turns it back on. R9 stated his bottom hurts bad as well as his hips and his legs. R9 stated he has had to wait for them to change his depends and when the urine sits on his skin it burns, like it is right now. R9 stated he has been in his chair since 11:00 AM and he starts hurting about an hour after he gets up. R9 stated the pain just gets worse and worse. R9 stated it makes him angry when they do this and he has never been angry in his life, but they are making him that way when they don't answer the call lights and/or provide care. R9 stated, "watch this." R9 pushed his call light at 3:03 PM. This surveyor did continuous observation from inside R9's room. At 3:25 PM this surveyor could hear staff talking in the hallway outside R9's room. Staff entered R9's room at 3:32 PM and R9 told them he wanted to go to bed. They left and returned with a mechanical lift at 3:38 PM. This indicates R9's call light was unanswered from 3:03 PM until 3:32 PM.

On 11/10/2022 at 12:15 PM, R9 stated, he would like to report another late call light experience that just happened. R9 stated, today (11/10/22) at

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S9999	Continued From page 9 about 11:00 AM, he was in bed, turned on his call light wanting to get up, and an unidentified staff member came in the room and shut off his light. R9 stated, he waited and called the nurses station to have them get him up and was told they would send someone to his room. R9 stated, he did not know names of any of the staff because he did not ask and they do not wear name tags. R9 showed his phone to surveyor with a call to the facility at 11:39 AM. R9 stated, at about 12:00 PM he turned on his call light again and a CNA came in and got him up within about 5 minutes. R9 stated, he has reported call light issues to administration before and nothing has been done about it. R9 stated, his roommate (R7) also has issues with staff not answering his call light timely. 3. R6's facility Admission Record with a print date of 10/20/22 documents R6 was admitted to the facility on 8/16/22 with diagnoses that include encounter for surgical after care, diabetes, morbid obesity, chronic kidney disease, mild cognitive impairment, hypertension, and necrotizing fasciitis. R6's MDS dated 8/23/22 documents a BIMS score of 12, which indicates R6 has a moderate cognitive impairment. Section G of R6's MDS documents that R6 requires assist of two staff for bed mobility, transfers, and toilet use. R6's undated care plan documents under the Focus area, "I have an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) obesity, DM II (type 2 diabetes), mild cognitive impairment" with interventions that include "R6 requires extensive assist by 2 staff for toileting and transfer."	S9999		

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S9999	Continued From page 10 On 10/18/22 at 5:44 AM, R6's call light was observed on. R6 stated her call light had been on for about 20 minutes. R6 stated that is about the average time it takes for a call light to be answered. R6 stated she has waited for up to four hours before to get assistance to be lifted with the mechanical lift. R6 stated she recently had a catheter removed and has some urge incontinence. R6 stated the light situation is so frustrating. R6 stated staff will come to her room, turn the call light off, say they need to find someone to help them, then leave, and you never know when they will come back. R6's call light remained on throughout the interview with at least one unidentified staff member passing by her room during the interview. R6's call light was observed on and not answered until 6:16 AM. This indicates R6's call light was unanswered by staff for 32 minutes. On 10/18/22 at 3:00 PM, when asked if she had residents complain call lights weren't being answered timely V8 (CNA) stated, "Absolutely." V8 stated R6 was very appreciative of the care V8 provided and had reported to V8 that R6 will have a need for something that requires two people such as a mechanical lift transfer and R6 reported it may be up to four hours before she gets assistance. V8 stated she told R6 she could talk with V2 (DON) about it and R6 declined on that day. On 10/25/22 at 10:12 AM, R6 was observed sitting in her recliner in her room with her family at her side. R6 stated she had to wait an hour yesterday (10/24/22) when she needed a mechanical lift to get up. On 10/27/22 at 3:55 PM, R6 was observed sitting in the recliner in her room. When asked if there	S9999		

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was any negative impact when it took a while for staff to answer her call light R6 stated, "It makes me feel like I don't matter." R6 stated she had a urinary catheter until recently and she is supposed to be doing bladder training since it has been removed. R6 stated it is really hard to train your bladder when it takes two and a ½ hours for them to answer the call light. R6 stated she has been bladder training herself in her incontinence brief.

4. R7's facility Admission Record with a print date of 10/26/22 documents R7 was admitted to the facility on 3/1/21 with diagnoses that include acquired absence of left leg below the knee, lack of coordination, diabetes, Mild Intellectual Disabilities, chronic kidney disease, schizoaffective disorder, and hypertension.

R7's MDS dated 10/12/22 documents a BIMS score of 11, which indicates R7 has a moderate cognitive impairment. Under Section G, the same MDS documents R7 requires assist of two staff for transfers and toileting.

R7's undated Care Plan documents a Focus area of "I have an ADL self-care performance deficit r/t Mild Intellectual disabilities and lack of coordination." Interventions documented on the care plan include, "Toilet Use: R7 is dependent on mechanical and 2 staff with toileting at this time. Transfer: R7 is dependent on mechanical lift and 2 staff for transfers between areas as necessary."

On 10/25/22 at 2:12 PM, R7 was observed sitting in his room. R7 stated the facility staff don't answer call lights timely. R7 pushed his call light at 2:13 PM. A CNA came into R7's room almost immediately and he told her he was wanting to get up. She stated she would have to get the

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S9999	Continued From page 12 mechanical lift after other staff were finished using it and would be right back. On 10/25/22 at 2:38 PM, this surveyor observed R7's call light back on. Upon entering the room R7 was observed still laying in bed. R7 stated staff haven't been back in to get him up. On 10/25/22 at 2:42 PM, R7 was observed still in bed, and he stated staff keep coming in and turning his call light off and saying they have to get help and will be right back. At 2:48 PM staff are observed entering R7's room with a mechanical lift. This indicates R7 waited 36 minutes for staff to assist him out of bed. 5. R8's facility Admission Record with a print date of 10/20/2022 documents R8 was admitted to the facility on 6/12/21 with diagnoses that include chronic obstructive pulmonary disease, hypertension, cognitive communication deficit, major depressive disorder, and abnormalities of gait and mobility. R8's MDS dated 8/27/22 documents a BIMS score of 14, which indicates R8 is cognitively intact. Section G of R8's MDS documents that R8 requires two-person physical assist for transfers and toileting. R8's undated care plan documents a Focus area "I have an ADL self-care performance deficit r/t decreased mobility, lack of coordination" with interventions that include R8 requires extensive assist by 2 staff for toileting and R8 requires a mechanical lift with two staff to move between surfaces. R8's care plan documents a Focus area of "I am a non-reliable responder" with interventions that include, "Allow resident to voice perceptions thru active listening, ask open ended questions, investigate resident statements and/or concerns, praise factual statements, redirect with	S9999		

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S9999	Continued From page 13 kindness, do not argue with resident." On 10/18/22 at 6:00 AM, 6:15 AM, and 6:21 AM R8's call light is observed on. On 10/18/22 at 6:21 AM, R8 was observed lying in bed. R8 stated the facility staff were supposed to have gotten her up at 5:00 AM. When asked why they were to get her up that early R8 stated "Because I wanted to get up." R8 stated she put her light on at 5:00 AM and told the staff last night she wanted to get up at 5. When asked if it normally takes a while for them to answer call lights R8 stated, "Oh my God, yes, sometimes 2-3 hours." When asked if anything negative had happened when it took staff awhile to answer her call light R8 stated, "wet the bed, pooped the bed." On 10/18/22 at 6:45 AM, staff entered R8's room to assist her up. Aside from R8's verbal report of activating her call light at 5AM, R8's call light was visually seen by this surveyor as unanswered from 6:00 AM until 6:45 AM, indicating her call light was on for 45 minutes. On 10/18/22 at 12:58 PM, V6 (CNA) stated they usually have three CNA's, a shower aide, and a restorative aide on "Daisy" and two CNA's on "Rose." When asked if this is enough staff to provide care for the residents, V6 stated she believed so. When asked why it took so long answer the call lights on the morning of 10/18/22, V6 stated she wasn't sure. V6 stated she wasn't at the facility the whole time. V6 stated she usually gets to the facility around 6:00 AM. V6 stated night shift didn't say anything about the light being on or how long it had been on. On 10/18/22 at 3:00 PM, when asked if 45	S9999		

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S9999	Continued From page 14 minutes was too long for a call light to not be answered, V8 (CNA) stated she thought a call light that was not answered for that long could be dangerous. 6. R20's facility Admission Record with a print date of 11/3/22 documents R20 was admitted to the facility on 6/4/22 and discharged from the facility on 8/3/22. R20's diagnoses listed on the Admission Record include Clostridium difficile, diarrhea, anxiety disorder, acute kidney failure, hypertension, cognitive communication deficit, hematuria, vertigo, urinary tract infection, and lack of coordination. R20's MDS dated 7/9/22 documents a BIMS score of 12, which indicates R20 has a moderate cognitive impairment. The same MDS Section G documents R20 requires assist of two staff for transfers and toileting. R20's facility care plan with a Focus area of "I have an ADL self-care performance deficit r/t" with interventions of "Transfer: R20 requires limited assist by 1 staff at times to move between surfaces as necessary. PT/OT (physical therapy/occupational therapy) evaluation and treatment as per MD (physician) orders. The facility Concern/Compliment Form dated 7/6/22 documents under Nature of Concern/Compliment "waited over an hour to be changed, yelling out for help. Resident (R20) say (sic) he wearing (sic) Put in bed and did not change, left me there, change clothes finally this morning. His bottom is red and hurts." On 10/19/22 at 12:55 PM, V10 (Social Services Director) stated R20 was discharged home. V10 stated she was the one who assisted him with his	S9999		

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concern. V10 stated R12 had his call light on, and staff came down and put him to bed without changing him. V10 stated they didn't put his pajamas on and left R20 in his clothes. V10 stated R20 had Clostridium Difficile (C-diff) and would sometimes have accidents and he was supposed to get assistance to go to the bathroom. V10 stated R20 reported to her that he knew the staff hear residents hollering all day and night. V10 stated he was a little upset, but he just wanted the facility to know what happened. V10 stated she thought R20's bottom was red and hurting because of the C-diff not because he had been left all night without changing him. V10 stated R20 reported they would pass the call light up and he would yell out and the staff weren't responding to him. V10 stated R20 went an hour until someone came and answered his call light and took him to the bathroom, but he went all night in his clothes.

The facility Resident Council meeting minutes documents the following, 5/11/22 "Old business ...Hard to get help in rooms during mealtimes." 6/8/22 "Old Business. Hard to get help in rooms at meal times- Getting better." 7/13/22 " Nursing Call lights- Not answered on timely manner." 8/10/22 " ...Nursing: Call lights not getting answered timely." 9/14/22 " Nursing: Call lights looked (sic)" 10/12/22 " Nursing: Good- Still need work on call lights. Residents waiting long periods to be laid down."

The facility Complaint Resolution Form dated 7/13/22 documents, "Problem: Call lights- Not answered on a timely manner. Department: Nursing. Resolution: Call light education for staff on 7/25/22."

The facility Complaint Resolution Form dated

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S9999	Continued From page 16 8/10/22 documents, "Problem: Call light not answered timely manner Resolution: call light response time will be monitored " There were no other Complaint Resolution Forms provided to this surveyor. On 10/19/22 at 12:55 PM, V10 (Social Services Director) stated she was responsible for reviewing and following up with some of the facility grievances/resident council meeting concerns. V10 stated they have had concerns with call lights not being answered timely brought up in resident council meetings. Reviewed with V10 the resident council meeting minutes that document concerns for the past four months. When asked what the facility has done to address the call light concerns V10 stated they had educated staff, including non-nursing staff that anyone can answer the call light. V10 stated if the person that answers the call light is not able to fulfill the need, they should pass it on to the nursing staff and then follow up with the resident in 15 minutes to ensure the need was met. V10 stated she also knows the facility did a questionnaire and an in-service, but she wasn't involved in implementing those. On 10/20/22 at 6:45 AM, when asked if she knew why call lights weren't being answered timely, V14 (LPN), stated if they put the call light on when supper trays go out or in the morning when people are getting up it may extend the time it takes to answer them. On 10/21/22 at 1:55 PM, when asked how quickly call lights should be answered V2 (DON) stated, "In a timely fashion." V2 stated they have educated staff on answering call lights timely and are implementing nursing staff and CNA staff to	S9999		

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S9999	Continued From page 17 come in at different times so they can monitor call lights better. V2 stated they did a call light audit, but she felt it would be more accurate if they had a different system. V2 stated she has also come to the facility at different times at night to audit call lights. On 10/26/22 at 9:41 AM, when asked when he became aware call lights weren't being answered timely and what the facility did about it, V1 stated, the majority of call lights happen all at the same time. V1 stated that is when everyone wants to lay down or get up. V1 stated he has tried to teach staff to prioritize call lights and they have done call light audits. V1 stated it usually takes them about 10 minutes on average to answer the lights. This surveyor informed V1 that call light observations revealed they weren't answered for 30-45 minutes on the morning of 10/18/22, and he stated that is when everyone wants to get up and the nursing staff are doing their rounds during that time frame. When asked if that was an appropriate time frame for call lights to be answered V1 stated he would like to see them answered sooner than that. This surveyor informed V1 that R8 stated she wanted to get up at 5:00 AM and V1 stated that was funny because R8 never wanted to get up early. When asked if he thought R8 really didn't want to get up early V1 stated, "No." She (R8) is one who could lay in bed all day and never want to get up. When asked what his expectation would be in the situation where staff turn the call light off, leave, and don't come back, V1 stated he would expect them to go back and finish the task or leave the call light on until the need is met. Reviewed with V1 the observation on 10/25/22 of staff telling R7 they would have to wait for the mechanical lift and V1 stated, maybe the battery wasn't charged on the mechanical lift, or some staff don't like to use the	S9999		

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S9999	Continued From page 18 manual lift, or one resident takes a lot longer to transfer. When asked if that was an acceptable time frame to wait to get up, V1 stated he would like it to be sooner, but it just depends on the circumstances. On 11/04/22 at 3:21 PM, V2 stated there is no specific time frame that call lights are to be answered in the facility call light policy. When asked how staff know what the expectations are regarding how quickly a call light should be answered, V2 stated, "they should just be prioritized by what resident needs, need to be met first." The facility Call Light policy dated 11/28/12 documents, "Purpose: To respond to residents' requests and needs in a timely and courteous manner. Guidelines: Resident call lights will be answered in timely manner. 1. All residents that have the ability to use a call light shall have the nurse call light system at all times and within easy accessibility to the resident at the bedside or other reasonable accessible location. 2. All staff should assist in answering call lights. Nursing staff members shall go to resident respond to call system and promptly cancel the call light when the room is entered. 3. Bathroom lights should be viewed as emergencies and immediate attention will be given. 4. Requests shall be responded to in a courteous and professional manner. 5. Hand bells will be provided for alert dependent residents when position out of reach of permanent call light when needed. 6. Call bell system defects will be reported promptly to the Maintenance Department. Check room frequently until system is repaired ..." The facility Daily Census dated 10/16/22 given to this surveyor on 10/18/22 documents 67	S9999		

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S9999	Continued From page 19 residents reside at the facility. (B) 2/4 300.610a) 300.680c) 300.1210b) 300.3210t) 300.690a) 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. Section 300.680 Restraints c) Physical restraints shall not be used on a resident for the purpose of discipline or convenience. 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	S9999		

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S9999	Continued From page 20 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. Section 300.1210 General Requirements for Nursing and Personal Care 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 regulations were not met as evidenced by: (A) Based on observation, record review, and interview the facility failed to ensure residents were not restrained for staff convenience for 1 of 3 (R3) residents reviewed for restraints in the sample of 20. R3 who has a severe cognitive	S9999		

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S9999	Continued From page 21 impairment, had a fall on night shift, was unsteady on his feet, and refusing to stay in bed. Facility staff placed R3's mattress on the floor and placed R3 on his mattress. R3 was unable to stand up from the floor and crawled on his hands and knees to the door and asked for help. A reasonable person would have felt humiliation, fear, had loss of dignity, anxiety, and agitation, as well feelings of being dehumanized by being placed in a position they were only able to crawl away from. (B) The facility failed to ensure falls were investigated, new and/or appropriate interventions to prevent falls were implemented, and appropriate levels of supervision were in place to prevent injury for 4 of 4 residents (R2, R3, R4, and R5) in the sample of 20 investigated for falls. This failure resulted in R3 having four falls from 9/9/22 to 10/19/22 that resulted in hematomas and lacerations to his head with neurological checks not completed per facility policy, multiple bruises and cuts, and a subsequent stay at a mental health facility for a medication evaluation and adjustment Findings Include: R3's Admission Record with a print date of 10/20/22 documents R3 was admitted to the facility on 4/24/2019 with diagnoses that include Alzheimer's Disease, dementia, hypothyroidism, dysphagia, brief psychotic disorder, chronic kidney disease, mood disorder, and schizoaffective disorder. R3's MDS (Minimum Data Set) dated 9/8/22 documents a BIMS (Brief Interview for Mental Status) score of 01, which indicates R3 has a severe cognitive impairment. R3's same MDS documents R3 requires assist of two staff for bed mobility and transfers. Under balance during	S9999		

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S9999	Continued From page 22 transitions and walking, R3's MDS documents R3 is "not steady, only able to stabilize with staff assistance." Under Functional Abilities R3's MDS documents, to go from lying to sitting on side of bed R3 requires partial/moderate assistance. R3's Restorative Observations dated 9/14/22 documents R3 is able to voluntarily move or reposition in bed and no restraints are in use. Under Care Plan it documents "(R3) is able to turn side to side, go from lying to sitting and sitting to lying with supervision and verbal cues of staff at times." R3 is supervision for transfers and supervision for locomotion and mobility at times. R3's progress notes document, 9/9/22 6:25 PM "Resident had a witnessed fall 09/09/2022 6:25 PM Location of fall: Residents room, Res (resident) found on floor in room and noted to have a small laceration to back of head, approx. (approximately) 3 cm. Resident assisted up and onto bed. Refuses to stay in bed, gait is unsteady and leaning backwards. Alert and disoriented per usual baseline. Assisted into bed but refuses to stay. Interventions: Mattress put on floor." R3's Fall IDT (Interdisciplinary Team) Note dated 9/12/22 10:10 AM documents, " Resident observed laying on floor in room, noted to have hematoma and laceration approx. 3 cm to back of head. Moves all ext (extremities) without difficulty or c/o (complaints of). Hollering get me up. Denies any c/o (complaints of) of discomfort. Neuro (neurological) checks initiated and WNL (within normal limits). Assisted up x (times) 2 staff and amb (ambulated) to bed. Refuses to stay in bed. Ambulating per self, gait is unsteady, and resident is leaning backwards when walking. Root Cause of fall: Resident lost balance, ambulating without assistance. Intervention and care plan	S9999		

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S9999	Continued From page 23 updated: Resident moved to room right across from nurse's station for increased monitoring." On 10/20/22 at 9:52 AM, V15 (LPN/Licensed Practical Nurse) stated, one-night (date unknown), R3 fell and bumped his head and she put his mattress on the floor that night. V15 stated R3 had a 2-3 cm laceration on the back of his head. V15 stated she did neuro (neurological) checks, fall monitoring, and behavior monitoring, called the physician, and gave R3 snacks. When asked how putting the mattress on the floor helped, V15 stated, "Well he wasn't able to get up." V15 stated she was the only one on that unit and she wasn't able to properly supervise R3. V15 stated the CNA (Certified Nursing Assistant) working with her on that night got sick and left the facility around 2:00 AM. V15 stated she tried to call people in, but no one was able to. V15 stated it is not typical to only have one staff member working on the unit. On 10/20/22 at 12:46 PM, this surveyor informed V2 (DON/Director of Nurses), of V15's interview of putting R3's mattress on the floor and V15 stated R3 couldn't get up. V2 stated she would consider putting R3's mattress on the floor a restraint and R3 isn't assessed for needing restraints. A statement by V15 dated 10/20/22 that was provided to this surveyor by V1 (Administrator) and V2 (DON) documents, "I spoke with the state surveyor concerning R3 the night he fell, I was alone on unit as the CNA scheduled was sick and left. R3 was restless, refusing to stay in bed. I told her he was restless, refusing to stay in bed. I also had told her I walked with him, gave him snacks and attempted to sit with him to calm him down. Ineffective. He was leaning backwards while	S9999		

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S9999	Continued From page 24 walking and balance was very poor and put his mattress on floor for his safety r/t (related to) balance and restlessness and attempting other redirection without success." On 10/21/22 at 12:02 PM, V20 (RN/Registered Nurse) stated she had never seen R3's mattress on the floor. V20 stated R3 would be able to get up from the floor without assistance. V20 stated she had never seen R3 get up from the floor, but he got out of his bed that was in a low position without assistance. On 10/26/22 at 1:08 PM, V23 (MDS Coordinator/Certified Restorative Nurse) stated he does restorative assessments on the residents and last assessed R3 on 9/14/22. V23 stated he saw R3 walking in the hallways after that assessment and wasn't aware of a decline in his functional capabilities. V23 stated he believed R3 could get up off the floor. V23 stated he believed R3 would have to crawl to some type of support to get up but that he could get up, once he had the support of a bed, wall, or chair. On 10/21/22 at 1:55 PM, when asked why R3's mattress wasn't still on the floor V2 (DON) stated they probably moved it after that because they came up with a different intervention. V2 stated they probably changed it because it didn't work, and they didn't want R3 to trip over it. On 10/26/22 at 9:41 AM, V1 (Administrator) was asked about R3's mattress being put on the floor as an intervention. V1 stated (V15) ensured the safety of the resident, and he was good with the mattress being on the floor, if it was being used as a safety measure. V1 stated he thought increased monitoring would have ensured R3's safety, so his mattress wouldn't have to be put on	S9999		

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S9999	Continued From page 25 the floor. On 11/01/22 at 4:20 PM, V15 (LPN) stated on 9/9/22 after she had moved R3's mattress to the floor R3 was able to get off the mattress and, did in fact get off it, while she was working that night. V15 stated R3 crawled on his hands and knees to the door of his room and asked for help. V15 stated she had to go to the other side to get another nurse to assist her in getting R3 off the floor. V15 stated she did not believe it would have been safe for her to assist R3 off the floor by herself. V15 stated she put R3 back in his bed and she believed he stayed there the remainder of the night. R3's undated Care Plan documents a Focus area of "I am at High risk for falls r/t (related to) dementia, reduce safety awareness and wandering behaviors. Goal: All falls will be reviewed by the IDT (Interdisciplinary Team) through next review." Interventions documented on the care plan are as follows, 4/29/19- Be Sure R3's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Encourage R3 to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as: walking to meals and activities. Review information on past falls and attempt to determine cause of falls. Record possible root causes. After remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes. 5/2/2019- Staff educated to make sure all personal items including water glass on the bed side table are in reach when in bed. 12/17/19-Sign (tractor) to be put on R3's door to	S9999		

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S9999	Continued From page 26 assist him while finding is (sic) room. 12/27/19-R3 needs activities that minimize the potential for falls while providing diversion and distraction. 3/4/20-Remove all tripping hazards from room at this time. 4/13/20- Staff to ensure that R3 has all items in reach when eating. 7/13/20-Encourage R3 is (sic) wearing appropriate footwear non-skid socks or shoes when ambulating as he allows. 12/15/21- Ensure rolling desk chair is securely pushed up under desk. Place stationary chair behind nurse's station. 9/12/22-R3 room relocated closer to nurse's station to increase monitoring. 10/19/22- Night light added to R3's room to decrease falls. 10/10/22-Staff to offer assistance when R3 is ambulating as he will allow. There is no restraint focus area documented on R3's undated care plan. The facility Abuse Prevention and Reporting - Illinois policy dated 11/28/16 documents, "Guidelines: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." (B) Findings Include: 1.R3's Admission Record with a print date of 10/20/22 documents R3 was admitted to the facility on 4/24/2019 with diagnoses that include Alzheimer's Disease, dementia, hypothyroidism, dysphagia, brief psychotic disorder, chronic kidney disease, mood disorder, and schizoaffective disorder.	S9999		

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S9999	Continued From page 27 R3's MDS dated 9/8/22 documents a BIMS score of 01, which indicates R3 has a severe cognitive impairment. R3's same MDS documents R3 requires assist of two staff for bed mobility and transfers. Under balance during transitions and walking R3's MDS documents R3 is "not steady, only able to stabilize with staff assistance." Under Functional Abilities R3's MDS documents to go from lying to sitting on side of bed R3 requires partial/moderate assistance. R3's Restorative Observations dated 9/14/22 documents R3 is able to voluntarily move or reposition in bed and no restraints are in use. Under Care Plan it documents "(R3) is able to turn side to side, go from lying to sitting and sitting to lying with supervision and verbal cues of staff at times. R3 is supervision for transfers and supervision for locomotion and mobility at times. R3's Fall Risk Assessment dated 10/18/22 documents a score of 12, which indicates R3 is at risk for falls. The facility fall risk assessment does not document if someone is at low, moderate, or high risk for falls. It documents if someone is at risk or not at risk for falls. R3's undated Care Plan documents a Focus area of "I am at High risk for falls r/t (related to) dementia, reduce safety awareness and wandering behaviors. Goal: All falls will be reviewed by the IDT (Interdisciplinary Team) through next review, Interventions: Be Sure R3's call light is within reach and encourage the resident to use it for assistance as needed (date initiated 4/29/19). The resident needs prompt response to all requests for assistance (date initiated 4/29/19). Educate the resident/family/caregivers about safety reminders	S9999		

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and what to do if a fall occurs (date initiated 4/29/19). Encourage R3 is (sic) wearing appropriate footwear non-skid socks or shoes when ambulating as he allows (date initiated 7/13/2020). Encourage R3 to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as: walking to meals and activities (date initiated 4/29/19). Ensure rolling desk chair is securely pushed up under desk. Place stationary chair behind nurse's station (date initiated 12/15/21). Night light added to R3's room to decrease falls (date initiated 10/19/22). Remove all tripping hazards from room at this time (date initiated 3/4/20). Review information on past falls and attempt to determine cause of falls. Record possible root causes. After remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes (date initiated 4/29/19). R3 needs activities that minimize the potential for falls while providing diversion and distraction (date initiated 12/27/19). R3 room relocated closer to nurse's station to increase monitoring (date initiated 9/12/22). Sign (tractor) to be put on R3's door to assist him while finding is (sic) room (date initiated 12/17/19). Staff educated to make sure all personal items including water glass on the bed side table are in reach when in bed (date initiated 5/2/19). Staff to ensure that R3 has all items in reach when eating (date initiated 4/13/20). Staff to offer assistance when R3 is ambulating as he will allow (date initiated 10/10/22)."

A) R3's progress notes documents, 9/9/22 6:25 PM "Resident had a witnessed fall 09/09/2022 6:25 PM Location of fall: Residents room, Res (resident) found on floor in room and noted to have a small laceration to back of head, approx. (approximately) 3 cm. Area slightly raised, dry

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drsg (dressing) applied. Resident assisted up and onto bed. Refuses to stay in bed, gait is unsteady and leaning backwards. No other signs of injuries present on 09/09/2022 6:25 PM. Assessment Unwitnessed fall, neurological checks initiated. Alert and disoriented per usual baseline. No changes in range of motion from normal baseline. New injury observed. Laceration to back of head approx. (approximately) 3 cm. Actions Taken: Dry drsg to back of head. Assisted into bed but refuses to stay. Interventions: Mattress put on floor." This progress note documents the fall as both witnessed and unwitnessed. The note then documents R3 was found on the floor in his room indicating it was an un-witnessed fall.

R3's neurological (neuro) checks were reviewed, and documents neuro assessments were completed on 9/9/22 at 6:40 PM, 6:55 PM, 7:25 PM, 7:55 PM, 8:05 PM, 8:35 PM, and 12:00 AM. Neuro checks were documented as completed on 9/10/22 at 12:35 AM and 8:35 PM. All neurological checks documented have vital signs dated 9/9/22 at 6:25 PM and a pain assessment dated 9/10/22 at 2:48 AM. This indicates R3 did not have neurological checks done 10 times during the 72-hour post fall period. The neurological checks also document R3's vital signs and pain assessment were completed once in the same 72-hour post fall period.

R3's Fall IDT (Interdisciplinary Team) Note dated 9/12/22 10:10 AM documents, " Resident observed laying on floor in room, noted to have hematoma and laceration approx. 3 cm to back of head. Moves all ext (extremities) without difficulty or c/o (complaints of). Hollering get me up. Denies any c/o (complaints of) of discomfort. Neuro checks initiated and WNL (within normal limits). Assisted up x (times) 2 staff and amb

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(ambulated) to bed. Refuses to stay in bed. Ambulating per self, gait is unsteady, and resident is leaning backwards when walking. Root Cause of fall: Resident lost balance, ambulating without assistance. Intervention and care plan updated: Resident moved to room right across from nurse's station for increased monitoring."

On 10/20/22 at 9:52 AM, V15 (Licensed Practical Nurse/LPN) stated one-night (date unknown) R3 fell and bumped his head and she put his mattress on the floor that night. V15 stated R3 had a 2-3 cm laceration on the back of his head. V15 stated she did neuro checks, fall monitoring, and behavior monitoring, called the physician, and gave R3 snacks. When asked how putting the mattress on the floor helped, V15 stated, "Well he wasn't able to get up." V15 stated she was the only one on that unit and she wasn't able to properly supervise R3. V15 stated the CNA (Certified Nursing Assistant) working with her on that night got sick and left the facility around 2:00 AM. V15 stated she tried to call people in, but no one was able to. V15 stated it is not typical to only have one staff member working on the unit.

On 10/20/22 at 12:46 PM this surveyor informed V2 (DON/Director of Nurses), of V15's interview of putting R3's mattress on the floor and V15 saying R3 couldn't get up. V2 stated she wasn't aware of them only having one nurse on the unit and no CNA's. V2 stated she would expect facility staff to call her if that happened. V2 stated she would consider putting R3's mattress on the floor a restraint and R3 isn't assessed for needing restraints.

A statement by V15 dated 10/20/22 that was provided to this surveyor by V1 (Administrator) and V2 (DON) documents, "I spoke with the state

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surveyor concerning R3 the night he fell, I was alone on unit as the CNA scheduled was sick and left. R3 was restless, refusing to stay in bed. I told her he was restless, refusing to stay in bed. I also had told her I walked with him, gave him snacks and attempted to sit with him to calm him down. Ineffective. He was leaning backwards while walking and balance was very poor and put his mattress on floor for his safety r/t (related to) balance and restlessness and attempting other redirection without success."
On 10/21/22 at 12:02 PM, V20 (RN/Registered Nurse) stated she had never seen R3's mattress on the floor. V20 stated R3 would be able to get up from the floor without assistance. V20 stated she had never seen R3 get up from the floor, but he got out of his bed that was in a low position without assistance.

On 10/26/22 at 1:08 PM, V23 (MDS Coordinator/Certified Restorative Nurse) stated he does restorative assessments on the residents and last assessed R3 on 9/14/22. V23 stated he saw R3 walking in the hallways after that assessment and wasn't aware of a decline in his functional capabilities. V23 stated he believed R3 could get up off the floor. V23 stated he believed R3 would have to crawl to some type of support to get up but that he could get up, once he had the support of a bed, wall, or chair.

On 10/21/22 at 1:55 PM when asked why R3's mattress wasn't still on the floor V2 (DON) stated they probably moved it after that because they came up with a different intervention. V2 stated they probably changed it because it didn't work, and they didn't want R3 to trip over it.

On 10/26/22 at 9:41 AM when asked about R3's mattress being put on the floor, V1

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S9999	Continued From page 32 (Administrator) stated, she (V15) ensured the safety of the resident. V1 stated he was good with the mattress being on the floor, if it was being used as a safety measure, but he thought increased monitoring would ensure that, so you didn't have to put the mattress on the floor. When asked if he was aware the CNA had to go home and there was only one staff member on the unit V1 stated he was not. V1 stated there were three CNA's working on the other halls and they would have floated over to that unit to help. On 11/01/22 at 4:20 PM, V15 (LPN) stated on 9/9/22 after she had moved R3's mattress to the floor R3 was able to get off the mattress and did in fact get off it while she was working that night. V15 stated R3 crawled on his hands and knees to the door of his room and asked for help. V15 stated she had to go to the other side to get another nurse to assist her in getting R3 off the floor. V15 stated she did not believe it would have been safe for her to assist R3 off the floor by herself. V15 stated she put R3 back on his mattress that was still located on the floor, and she believed he stayed there the remainder of the night. When asked if that was the only time another staff member came to the unit to assist her, V15 stated the other nurse came over to the unit around 5:30 AM so she could go to the other side to pass medications. When asked if she notified V1 or V2 she was the only staff working on the unit V15 stated the other nurse made the calls since she had been working at the facility longer and she knew she had attempted to call staff in but wasn't sure if she had attempted to call V1 or V2. B) R3's unwitnessed fall report dated 9/23/22 documents, "R3 was asleep in room with door to room closed. CNA (Certified Nursing Assistant)	S9999		

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S9999	Continued From page 33 was sitting at the nurse's station desk and she seen the resident open up his door. The resident had blood all over himself, the floor, and his bed, appearing to come from an open area on the back of his head, that also includes a knot area. Resident unable to give description. Description: The CNA called this nurse. and this nurse preformed an assessment, as able, due to resident's dementia and combative behavior. He appeared to be alert with confusion, able to stand and walk around and get in and out of his bed. The blood appeared to come from an open area to the back of his head. His vital signs were taken and he was assisted to the shower by 2 CNA's. Resident was very angry with getting a shower, he was yelling and hitting staff while shower was in progress Resident taken to hospital: Laceration back of head" R3's Fall IDT Note dated 9/23/22 documents " Intervention and care plan updated: Staff education for making sure door is open when not doing resident care." R3's neurological checks were reviewed, and documents neuro assessments were done on 9/23/22 at 3:45 AM, 6:30 AM, 10:30 AM, 2:30 PM, 6:30 PM, and 10:30 PM; and on 9/24/22 at 2:30 AM, 6:30 AM, and 2:30 PM, 9:25/22 at 6:30 AM and 2:30 PM. This indicates R3 did not have neurological assessments completed 7 times in the 72-hour post fall period. C) R3's 10/08/22 witnessed fall report documents, "R3 was walking down hall and lost balance and fell to right side onto floor, resident did not hit head. Immediate Action Taken: Resident trying to get self-up, staff helped resident up after assessed. No injuries at time of incident."	S9999		

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S9999	Continued From page 34 R3's Fall IDT Note dated 10/10/22 documents, " Intervention and care plan updated: Staff to assist resident with ambulation as he allows." D) On 10/18/22 at 6:42 AM, R3 was observed walking the length of the dining room and out into the hallway. R3 was wearing pajamas and no shoes. R3 was unsteady and stumbling some during this observation. R3 had dried blood on his shirt on the top of his left shoulder, on his left ear, and on his neck behind his left ear. There were no staff observed in the dining room or in the hallway. This surveyor noted V7 (CNA) behind the nurse's station in a small room eating breakfast. This surveyor notified V7 of the blood and she stated she thought the blood on his shirt was dried blood. This surveyor agreed with her that it was dried blood and pointed out the blood on R3's ear and neck. V7 stated she didn't know if it was something new and walked with R3 to a room located down the hall, not near the nurse's station. She then went back to the small room behind the nurse's station and began eating. R3 was observed two more times throughout the day on 10/18/22, both times he was in bed. Immediately following this observation and throughout the day on 10/18/22, R3's medical record was reviewed and did not document incident reports, assessments, or follow up related to the dried blood on R3's left ear/neck. On 10/18/22 at 1:30 PM, V7 (CNA) stated R3 had been really combative on 10/18/22. V7 stated they told the nurse about his ear, and she thinks maybe he scratched it. V7 stated they tried cleaning his ear, but he wouldn't let them. When asked if she was aware of any recent fall, V7 stated, there was nothing in report and nothing	S9999		

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S9999	Continued From page 35 happened on day shift on 10/18/22. (The most recent fall documented in R3's record was on 10/08/22.) On 10/20/22 at 6:30 AM, V13 (LPN/Licensed Practical Nurse) stated she didn't know what happened to R3's left ear. On 10/21/22 at 10:05 AM, V18 (CNA) stated she had provided care to R3 but not when he had any falls. When asked if she knew what happened to R3's ear V18 stated she had no clue. On 10/20/22 at 11:51 AM, V17 (LPN) stated she worked on Tuesday 10/18/22. When asked if she knew what happened to R3's ear V17 stated, just what she was told, that he had hit it on his bed or something the night before. (There is no documentation in R3's medical record of him hitting his head on the bed on 10/17/22). On 10/20/22 at 12:46 PM when asked about the injury to R3's ear V2 (DON) stated there was always an ongoing investigation for R3. When asked if I could see the investigation V2 stated she didn't have anything written on it that she could give me. After this interview V2 provided this surveyor with the following documentation on 10/20/22. R3's Skin Tear report dated 10/18/22 4:45 PM documents, "Resident ambulating falling back to hit the closet door with his left arm causing multiple skin tears to upper-elbow-forearm of left arm, wounds cleansed with wound cleanser non adhere drsg (dressing) applied arm wrapped with cling wrap and secured with tape." R3's Progress note dated 10/18/22 at 5:22 PM "Resident has been very restless, hitting the	S9999		

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	IL6009815	A. BUILDING: _____ B. WING _____	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE FAIRFIELD	305 N.W. 11TH STREET FAIRFIELD, IL 62837

(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
S9999	Continued From page 36 doors and walls with his hands, difficulty with sitting still, resident was in his old room and fell back against the closet doors and caused skin tears to back side of upper middle and lower left arm, combative with staff when trying to provide care, hitting, kicking, pinching, and biting at staff. Notified V4 (Physician) with new order received to give PM dose of Valium now and hold tonight dose. Notified ADON (Assistant Director of Nurses) and POA (power of attorney) of health care with a return call from (family member) with update on condition. Staff assist to DR (dining room) for supper meal resident unable to sit long enough to eat, carried around bowl of peas to eat." The skin tear report dated 10/18/22 at 4:45 PM and the progress note dated 10/18/22 at 5:22 PM indicate R3 did not have documentation in his medical record related to a fall prior to the observation on 10/18/22 at 6:42 AM that would account for the dried blood on his ear/neck. Upon requesting the investigation for the areas on R3's neck/ear this surveyor was provided with the following progress note. R3's 10/20/22 8:48 AM progress note documents, "Resident had fall, struck side of bed on LT (left) side of head, scratches to LT side of ear which is consistent with striking head on bed on LT side, Injury with dried blood was noticed within one day, healing was already taking place which is consistent with time of fall." This report has handwritten on it, "From 10/18/22 fall" This information is consistent with the information provided by V17 (LPN) in her interview on 10/19/22 at 11:51 AM. There is no other documentation in R3's medical record related to follow up, neurological checks, or new interventions related to a fall where R3 hit his	S9999		

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S9999	Continued From page 37 head on his bed. R3's Injury of Known report with the date cut off and not readable documents "Resident had a fall where he struck the left side of his head, scratch is on left side of head." This report was given to this surveyor with R3's progress notes dated 10/20/22 8:48 AM, attached to it. When asked for a copy of this report with the date viewable received the following risk management report from V2. R3's Risk Management report dated 10/20/22 8:48 AM documents, "Resident had a scratch to left ear." Under Description of Action Taken the report documents, "Resident had a fall where he struck the left side of his head, scratch is on left side of head." On 11/02/22 at 4:32 PM, V1 and V2 were asked to clarify the discrepancies in the progress notes, skin tear report, and risk management report. They stated they would see what they could find. As of 11/03/22 they had not provided this surveyor with any other information. On 11/04/22 at 9:49 AM spoke with V1 and V2 and explained that I needed clarification related to the different reports on R3's fall related to the area on his ear. V2 stated she had sent me the report with handwritten information at the bottom of the report. V2 stated she would see what else they had and send it to me. On 11/04/22 at 11:46 AM received an email with an Investigation of Skin Tear, Bruises, and Abrasions attached dated 10/18/22. The report documents the location as left ear with no description of injury documented. The report documents R3 had "several recent falls et (and)	S9999		

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S9999	Continued From page 38	S9999		

behaviors." Handwritten at the bottom of the report it documents, "We do weekly skin assessments, done 10/11/22, then 10/18/22. After wound was cleaned, it was a small scratch. R3 has many behaviors, including beating on walls and doors, tearing fixtures off of wall. R3's frequently taking clothes off, refuses to have nails trimmed, so resident does scratch self often. Scratch is consistent with resident behavior. Blood spot was found on resident pillowcase, consistent with scratch."

On 11/4/22 at 12:50 PM spoke with V1 and V2 related to the information provided in the email dated 11/4/22 at 11:46 AM. V2 stated R3 did not have any behaviors or falls on 10/17/22. V2 stated the skin tear report dated 10/18/22 at 4:45 PM and the progress note dated 10/18/22 at 5:52 PM are referencing the same incident that occurred at 4:45 PM. V2 stated she thinks the progress note dated 10/20/22 at 8:48 AM was when she was talking with nurses and trying to determine where the dried blood on R3's ear and neck had come from. V2 stated she assumed it came from the other fall. When asked what other fall she was referencing she stated the nurses had told her R3 had fallen by his bed. V2 then stated R3 didn't actually fall and hit his head on his bed, but she believes he scratched his ear while in bed.

E) R3's progress notes document the following on 10/19/22 at 7:27 AM "Resident up and down this shift, after fall resident made one on one so he would have supervision to prevent further falls, no s/s (signs of symptoms) of distress noted will cont (continue) to monitor." This is signed by V13 midnight shift nurse and is not documented as a late entry.

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S9999	Continued From page 39 R3's progress note dated 10/19/22 at 8:05 AM "Nurse contacted MD (physician) about resident behavior. New order rec'd (received) to give Valium early et (and) hold bedtime dose." This is signed by V2 (DON). On 10/19/22 at 10:30 AM this surveyor with V8 (CNA) present observed R3 lying in bed. R3 had a large red and purple hematoma on the left side of his head that went from the top of his forehead down his nose and across his face covering his left eye. When asked what happened V8 stated R3 had fallen last night but she didn't have any of the details. R3's Un-witnessed fall report dated 10/18/22 at 6:30 PM documents "This nurse was at nurse's station getting report, other nurse helped resident to bed, staff heard resident yelling help sitting in floor on bottom, trying to get up, resident noted to have hematoma to left forehead." Under description the report documents "resident helped to feet and bed; ice applied to forehead." R3's 10/19/22 3:47 PM Fall IDT Note documents, "This nurse was at nurse's station getting report other nurse helped resident to bed, staff heard resident yelling help sitting in floor on bottom, trying to get up, resident noted to have hematoma to left forehead. Root Cause of Fall: Resident in dark room. Intervention and care plan updated: Night light placed in resident's room to better see when room is dark." On 10/20/22 at 6:30 AM, V13 (LPN) stated she was working recently (unsure of date) when R3 had a fall. V13 stated they were in the middle of report, and she got up because R3 had been walking to the door and she put R3 in bed. V13 stated she continued to give report and then	S9999		

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S9999	Continued From page 40 heard R3 say help me. V13 stated R3 was sitting on his bottom with a hematoma on his forehead. V13 stated she had one of the girls sit with him one to one after that and made sure the chairs were out of his room. On 10/19/22 at 11:51 AM when asked if she felt they had enough staff to provide care for R3, V17 stated, "No I think he would need to be 1:1 to prevent falls and/or behaviors." On 10/19/22 at 1:35 PM, V12 (LPN) stated R3 did not have one to one ongoing but they are doing frequent checks on R3. V12 stated the one to one stopped about 7:00 AM on 10/19/22. On 10/21/22 at 1:55 PM when asked how R3 fell and got a hematoma to his head on 10/19/22 if he was 1:1, V2 stated, "That is a good question." When asked if he was supposed to be 1:1 at the time of the fall on 10/19/22, V2 stated they had sitters for R3 since the night of 10/18/22. When asked if she knew where R3's one to one sitter was when he fell on 10/19/22, V2 stated she hadn't looked into it yet. Reviewed R3's progress notes with V2 and she stated he should have been one to one at the time of the second fall. V2 then stated she doesn't know where the nurse got the order from and R3 probably fell during report. On 10/25/22 at 12:19 PM when asked if she had any more information on R3 having a 1:1 sitter when he fell on 10/19/22, V2 stated she did not. V2 stated she knew the staff kept an eye on R3 but there was no documentation of 1:1 monitoring. When asked if he was supposed to be 1:1 monitoring at the time of the fall V2 stated, "Yes the nurse had implemented it." When asked if there was someone with R3 when he fell V2 stated he would have been right there, someone	S9999		

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S9999	Continued From page 41 would have been close to him. When asked if there was a staff member right with R3 when he fell V2 stated it didn't seem like it. V2 stated she couldn't say for sure since she wasn't there, but it wasn't documented. On 10/26/22 at 12:46 PM, V1 (Administrator) stated R3 was made 1:1 short term on night shift on 10/18/22 after he fell and that when the IDT team met, they changed the intervention to a place a night light in his room since it was dark. V1 stated any resident who is to be placed 1:1 would be approved through him so he could get more staff to assist with monitoring and R3 had not been one to one other than the short time after a fall. This indicates R3's progress notes document on 10/19/22 at 7:27 AM R3 had a fall and the intervention implemented was 1:1 staff. R3's un-witnessed fall report documents the fall on 10/18/22 at 6:32 PM. R3's 10/19/22 7:27 AM progress note does not document if it is a late entry and referencing the fall on 10/18/22 at 6:32 PM. V2's interview documents R3 was 1:1 with sitters beginning on 10/18/22. V2 did not investigate if R3 was supposed to have had a 1:1 sitter and if so where the 1:1 sitter was at the time of the fall on 10/19/22. F) On 10/19/22 at 3:45 PM, R3 was observed sitting on the side of a bed with no sheets on it, wearing torn pajama pants, a dressing was observed to R3's left hand, a hematoma to R3's left forehead, left cheek and left eye area is black/red/blue. R3 doesn't speak to this surveyor. There is a recliner next to the bed with the footrest raised and blankets in the recliner. V31 (LPN) was present with this surveyor and stated to R3 that he had gotten out of the recliner. V31	S9999		

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S9999	Continued From page 42 attempted to redirect R3 when he stood up from the bed. R3 was very unsteady on his feet. R3's soles of his feet were either bruised or dirty and there were scratches observed on the side of R3's left foot. R3's progress notes document on 10/11/22 at 10:00 PM, "Weekly skin observation completed for R3. Skin is warm, dry, within normal limits. Skin turgor is good. Skin Concerns: Skin concerns observed: Back of head-scabbed area from recent fall. No s/s of infection. No swelling, Skin concerns observed are not new." This skin assessment does not document any other areas observed to R3's skin. R3's progress notes document on 10/19/22 at 4:01 PM " Skin assessment completed today and V4 (Physician) notified for treatments for skin tears. Skin tear noted left wrist, old skin tear noted to left second digit and slight bruising starting around it. 3 skin tears noted near left elbow area, left upper forearm has a skin tear, old skin tear noted on right wrist, bruise noted on left shoulder area pinkish purple in color, right lower back has a small scab noted, abrasion noted behind left ear/neck, left lower ear lobe has a small open area like skin tear, bruising pinkish purple noted to center of upper chest, right buttocks and right post thigh has bruising and it is spreading to other side of buttocks and starting to go down scrotum and lower back, back of scalp has a small scabbed area left eye and cheek and forehead has dark purple pinkish red bruising and eye lids are swollen and left eye is reddened, right lower ext (extremity) has a small scab approx. (approximately) 1.5 cm (centimeter), left lower ext has a small scab approx. 0.5 cm long, few small scattered bruises noted to bil (bilateral) hands, pinkish purple bruising noted to right	S9999		

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S9999	Continued From page 43 temple area and right side forehead." On 10/20/22 at 6:30 AM when asked if they had enough staff to provide care for R3, V13 (LPN) stated, "Sometimes." V13 stated lately R3 had not been easily redirected and she thinks it started when he started the Valium. V13 stated R3's feet aren't bruised they are just dirty because he refuses to cover his feet On 10/26/22 at 9:41 AM when asked if he investigated the injuries of unknown origins including the bruises noted on R3's skin assessment from 10/19/22, V1 (Administrator) stated they were just going by the several falls that he had and his picking. V1 stated R3's behaviors have been escalating for the past month. When asked how he knew the injuries came from the falls/behaviors and didn't come from abuse, V1 stated, "I interview, I look at the bruising, the type of bruising, and determine if it is consistent with the fall." When asked for that investigation documenting those findings, V1 stated he didn't have one in writing, but he could write it up for me. On 11/0/1/22 at 5:36 PM, V1 provided this surveyor with the following investigations: R3's Investigation of skin tear, bruises, abrasions dated 10/18/22 documents "left ear" under location with no type or description of injury documented. The areas of "First noted by whom, Date, Time, Date/Shift of last shower, and transfer status, Equipment, any new assistive devices or equipment, any signs/symptoms of infection, Resident interview, Most likely cause, Staff interviews conducted, New intervention, Care plan updated, Investigation Completed by, Date, and Reviewed by Administrator" are all	S9999		

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S9999	Continued From page 44	S9999		

blank. Under "Recent Fall or injury-date and specifics" it documents, "several recent falls et (and) behaviors." Handwritten at the bottom of the report it documents, "We do weekly skin assessments, done 10/11/22, then 10/18/22. After wound was cleaned it was a small scratch. R3 has many behaviors including beating on walls et doors, tearing fixtures off of wall. Resident frequently taking clothes off, refuses to have nails trimmed, so resident does scratch self often. Scratch is consistent with resident behaviors. Blood spot was found on resident pillowcase consistent with scratch." V1 (Administrator) verified via email on 11/07/22 at 11:49 AM the skin assessment referred to in this investigation is the same as the assessment dated 10/19/22. V1 stated the assessment was started on 10/18/22 and completed on 10/19/22.

R3's Investigation of Skin Tear, Bruises, and Abrasions dated 10/08/22 documents a bruise to right posterior thigh. Under description of area, it documents right side. Under Resident Fall or injury- date and specifics the report documents, "Resident had recent fall 10/8/22 in hallway landing on right side. The following areas are blank on the report, Recent IV therapy, Recent LOA (leave of absence) with family, Equipment, any new assistive devices or equipment, any signs/symptoms of infection, Resident interview, most likely cause, staff interview conducted, new interventions implemented, and care plan updated. With no person documented under Investigation completed by and no date of completion documented.

R3's Investigation of Skin Tear, Bruises, and Abrasions dated 10/19/22 documents a bruise to left buttocks noted on 10/19/22. Under Recent Fall or injury- date and specifics the report

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S9999	Continued From page 45 documents, "had recent fall in room landing on buttocks." The remainder of the report is blank except the resident interview is marked as NA and reviewed by DON (Director of Nurses) and Reviewed by Administrator has signatures. The areas of staff interviews, equipment observed, most likely cause, and investigation completed by, and date are all blank. At the end of the report the following is handwritten in, "Due to recent falls IDT (Interdisciplinary Team) team and family (POA) send to (name of mental health hospital) for med review." R3's Investigation of Skin Tear, Bruises, and Abrasions dated 10/19/22 documents a bruise to left 2nd digit noted on 10/19/22. Under Recent Fall or injury -date and specifics the report documents, "had recent fall hitting closet door and hits second doors." The areas of staff interview, observing equipment, investigation completed by, and date are all blank. This indicates the investigations into the bruises of unknown origin identified on 10/19/22 were not complete or thorough. The bruise to R3's chest and the area behind R3's left ear is not addressed in these investigations. The investigations were also dated prior to V1's interview that documented he did not have written investigations of the areas identified on R3's 10/19/22 skin assessment. R3's Medication Administration Record dated 10/01/22 to 10/31/22 includes the following physician orders Seroquel 25 milligrams (mg) three times daily for schizoaffective disorder with a start date of 9/15/22, valium 5 mg at bedtime with a start date of 9/15/22 and a discontinue date of 10/13/22, valium 2.5 mg at bedtime with a start date of 10/13/22, and Lexapro 10 mg in the	S9999		

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S9999	Continued From page 46 morning for anxiety/depression with a start date of 7/14/22. On 10/19/22 at 11:14 AM, V30 (Family Member) stated she was just at the facility and talked with them about transferring R3 to a regional mental health hospital for evaluation. V30 stated she was notified about a month ago he was on Valium and R3 was started on several other medications that were not working. V30 stated now R3 is falling. On 11/03/22 at 2:01 PM when asked who initiated the transfer to the regional mental hospital V30 stated the facility social services had started the process of the transfer. V30 stated when she was at the facility on 10/19/22 and saw the condition R3 was in she told them she wanted him sent to the hospital. R3's regional mental health hospital record admission date 10/21/22 documents, R3 was admitted to the (name of hospital) on 10/21/22 for increased aggression. While here, he was made a 1:1 with a staff member at all times due to his poor safety awareness and high risk for falls. On 10/22/22, he was started on Keflex 500 mg twice daily for seven days for a skin infection. He was also started on wound care to affected skin tears and began Gentamycin eye drops for an eye infection. On 10/22/22, his Seroquel was discontinued due to no longer being effective and he started on a trial of Risperdal 0.25 mg twice daily for aggression. He was also started on an iron supplement on 10/25/22. He has not been tolerating oral medications or nutrition while here. It is the recommendations of the medical physician that R3 be discharged to a skilled nursing facility on comfort measures. On 10/21/22 at 11:30 AM, V4 (Physician) stated he was aware of all of the falls R3 had and stated	S9999		

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S9999	Continued From page 47 the problem with him is he is on the wrong medication (referring to Valium). V4 stated he was not able to do anything about it since he was not the prescribing physician. On 11/01/22 at 4:32 PM, V2 stated V4 (Physician) had prescribed R3's Valium. V2 stated they sent R3 to a mental health hospital for evaluation of his medications because they considered that may have been the reason for the increase in falls R3 was having. V2 stated R3 returned late on Friday evening (10/28/22). V2 stated they had adjusted R3's medications and he hasn't had any falls since his return to the facility. R3's Order Audit Report with a print date of 11/10/2022 documents the order for Valium 5 mg with a start date of 9/15/22 was electronically signed by V4 (Physician) as the prescribing physician. The drug interactions listed for Lexapro, Seroquel, and Valium found at Drug Interaction Report: Seroquel, Valium, Lexapro (drugs.com) include a moderate interaction between Seroquel and Valium and Lexapro and Valium that documents, "Some people, especially the elderly, may also experience impairment in thinking, judgement, and motor coordination." This indicates R3 had multiple falls after starting the combination of Lexapro, Seroquel, and valium. The facility was asked for information documenting the medications were reviewed and/or considered as a reason for R3's falls with subsequent action taken to prevent future falls. R3's Investigation of Skin Tear, Bruises, and Abrasions dated 10/19/22 was provide to this surveyor and documents a handwritten note at the bottom that documents "Do (sic) to recent	S9999		

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S9999	Continued From page 48 falls IDT team and family (POA/Power of Attorney) send to (name of mental health hospital) for med review." 2. R5's Admission Record with a print date of 10/20/2022 documents R5 was admitted to the facility on 10/07/22 with diagnoses that include chronic kidney disease, cardiac arrythmia, dependence on renal dialysis, type 2 diabetes, morbid obesity, atrial fibrillation, and person injured in unspecified vehicle accident. R5's MDS dated 10/08/22 documents a BIMS score of 15, which indicates R5 is cognitively intact. Section G of R5's MDS documents R5 requires two-person physical assist for transfers and one-person physical assist for bed mobility. R5's undated care plan documents a Focus area date initiated 10/08/22 of "I am at (Specify High, Moderate, Low) risk for falls r/t (related to). Goal: I will not sustain serious injury through the review date. Date initiated: 10/08/2022, Target Date: 01/06/2023, Interventions/Tasks: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt responses to all requests for assistance. Date initiated 10/08/2022." R5's Fall Risk Assessment dated 10/07/22 documents a score of 9, which indicates R5 is not at risk for falls. R5's progress notes document on 10/12/2022 7:30 AM "Fall Initial Occurrence Note, Fall Description: Resident (R5) had an un-witnessed fall 10/12/2022 6:30 AM, Location of Fall: Resident room, resident attempted to arise from recliner to take self to bed. Resident slid from	S9999		

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recliner to the floor. Resident stated no injuries were obtained on 10/12/2022 6:30 AM. Assessment: Witnessed Fall- Did not strike head; Neurological checks not indicated. Alert and oriented to time, person, place, and situation. No changes in range of motion from normal baseline. No injuries observed. Actions/Interventions: Notifications: Name and Designation: V4 (Physician) (contact information) V5 (Family Member) (contact information) 10/12/2022 7:00 AM. Actions Taken: Multiple staff assisted resident from floor to recliner. Full body assessment completed with no findings of any new areas. Daughter insisted that resident be seen in the ER (emergency room). Resident was seen in ER with a full work up completed, IVF (Intravenous Fluids) administered, labs drawn, and CT (computerized tomography) of head completed. Resident returned to facility with daughter escorting him. Report given by ER nursing staff and no areas of concern noted. No findings all test negative. No new orders given at time to discharge from emergency room. Intervention: Non- skid slip socks, frequent observations, re-educate resident frequently to use call light, assure call light and cell phone is within reach at all times. Vitals Hypotension: Medications reviewed, and areas of concerns noted R/T (related to) consistent low blood pressure. V4 notified and full admission assessment completed. V4 will continue to monitor."

R5's Progress Notes document on 10/12/2022 08:20 AM "Fall IDT (Interdisciplinary Team) Note: Attendees Present: DON (Director of Nurses), ADON (Assistant Director of Nurses), MDS (Minimum Data Set Coordinator), SS (Social Services), ADM (Administrator), Summary of Fall: Resident attempted to arise from recliner to take

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self to bed, resident slid from recliner to the floor. Resident stated no injuries were obtained. Root Cause of Fall: Resident taking new B/P (blood pressure) med (medication) which caused hypotension. Intervention and Care plan updated: Contacted MD (Physician) to do Med Review."

The facility undated Un-witnessed fall report documents under Incident Description, "Resident attempted to arise from recliner to take self to bed. Resident slid to the floor. Resident stated no injuries were obtained. Resident Description: "I don't remember what happened. Immediate Action Taken: Full body assessment completed vitals obtained. Staff assisted resident back to recliner. Resident taken to Hospital " Under Mental Status", oriented to place, time, person, situation, resident was able to call for help, and call light was within reach are all marked. The only two areas not marked under this section is disoriented, but wnl (within normal limits) for this and resident did not call for help. Under Notes the report documents, "Resident Stated, "doesn't really understand what took place has been having periods of black out moments."

On 10/19/22 at 9:32 AM, R5 was alert and oriented and asked about his fall on 10/12/22. R5 stated he was sitting in his chair in his room and must have dozed off. R5 stated when he woke up, he had slid down the front of his chair and couldn't get back up. R5 stated he tried to find the call light but couldn't find it at first. R5 stated he hollered out several times. R5 stated he then found the call light and pushed it around 2:00 AM. R5 stated the facility staff finally came in after 6:00 AM and got him up and took him to the bathroom. When asked how he knew how long he was laying in the floor R5 stated because he could see the clock on the wall.

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S9999	Continued From page 51 On 10/27/22 at 10:39 AM, surveyor observed the room where R5 resided while at the facility. The beds in the room were facing a wall with a clock in the center of that wall. A recliner was beside one of the beds also facing the wall with the clock. The clock was noted to have accurate time displayed. The facility Concern/Compliment Form dated 10/13/2022 documents under Nature of Concern/Compliment, "R5 stated that he slid out of his recliner into the floor. Resident (R5) stated he doesn't know what happened or how long he had been there. Stated he has moments where "he forgets." Under Summary of Pertinent Findings, the report documents, "After investigating incident, resident was found to be in floor for only a short amount of time. No injuries noted." Under Corrective Actions Taken: "Staff educated on timely call light monitoring." On 10/18/22 at 4:00 PM, V5 (Family Member) stated R5 was admitted to the facility for physical therapy after a hospital stay for a motor vehicle accident with a subsequent brain bleed. V5 stated R5 appeared somewhat confused at the facility on 10/11/22 and she requested a repeat CT scan be done to ensure the brain bleed was not worsening. V5 stated she again requested the repeat CT scan after R5 had fallen because she was concerned the fall on 10/12/22 could have also worsened it. V5 stated after she got off work on 10/12/22 the CT scan still had not been ordered so she took R5 to the local emergency room for evaluation. V5 stated the CT scan at the local hospital showed the brain bleed was improving. R5's local hospital emergency room record dated 10/12/22 documents R5 was evaluated at the	S9999		

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local hospital at 2:33 PM for a fall. Under Assessment R5's hospital Nurse's Notes documents, " Patient brought to ER (emergency room) from (name of facility) by family member who reports patient fell at nursing home this morning. Patient was in floor for approx. (approximately) 4 hrs (hours) and is unsure if he slid off the bed or had stood up and fell. Patient is slightly confused and family states that patient has been declining cognitively since Sunday. Family reports she requested nursing home have a ct of the head done but the order had never been obtained." Under additional history R5's hospital record documents, "AMS (altered mental status) x (times) 2 days. Recent Subarachnoid bleed from MVC (motor vehicle crash) 10/3/22, possible fall early this AM."

On 10/18/22 at 3:00 PM, V8 (CNA) stated R5's call light was on when she got to work on 10/12/22. V8 stated she answered a different residents call light first and provided care to that person then went to R5's room. V8 stated when she entered R5's room she saw him on the floor in front of his recliner with his head in front of his recliner. V8 stated R5 appeared to have missed his chair when sitting down. V8 stated she immediately went to get the nurse to assess R5. V8 stated R5 reported to them he had been laying there for hours and had been calling for help.

On 10/21/22 at 12:02 PM, V20 (LPN) stated she was working on 10/12/22 when R5 fell. V20 stated the CNA told her he had fallen. V20 stated it was after she had given report to oncoming day shift. V20 stated it appeared as if R5 had fallen out of his recliner. V20 stated she couldn't remember if R5's call light was on at that time, but she knew it wasn't on when she was on that hall around 4:30 or 5:00 AM. V20 stated she was

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pretty sure R5 had received medications on the morning of 10/12/22. V20 stated she wasn't sure, but she knew she was in the room next to R5's that morning and had a conversation with the CNA's in the hallway right outside R5's room. Reviewed R5's 10/1/22 to 10/31/22 MAR and it does not document medications were administered on the morning of 10/12/22. V20 stated R5 did not have any significant injuries.

On 10/26/22 at 10:30 PM, V21 (CNA) stated she took care of R5 on the night of 10/11/22. V21 stated she went into R5's room around 8:30 PM and R5 was sitting in his recliner. V21 stated she then went on break and when she got back from break, she went back into R5's room. V21 stated R5 reported he had slid out of his recliner and was able to get himself back into it. V21 stated she couldn't remember if she reported it to the nurse working that night. V21 stated she couldn't remember if R5 used his call light on the night of 10/11/22 or the morning of 10/12/22. V21 stated she couldn't remember when exactly they were in R5's room that night but she checks on every resident every couple of hours. Reviewed with V21 R5's medical record that documents a fall at 6:30 AM but not at 8:30 PM, V21 stated R5 had also fallen out of his recliner around 8:30 or 9:00 PM on 10/11/22.

On 10/26/22 at 10:40 PM, V22 (CNA) stated R5 reported falling out of his recliner after she came back in from break around 8:30 PM on 10/11/22. V22 stated she thought the nurse was in the room with R5 when she came in from break. V22 stated she couldn't remember what nurse was working. V22 stated she wasn't involved when R5 fell the second time on 10/12/22 at approximately 6:30 AM. V22 stated she was probably giving report. When asked how they give report V22

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stated they do rounds. When asked to explain what that means, V22 stated they go to each room and tell the oncoming shift what happened with the resident through the night. When asked if she remembered doing rounds on the morning of 10/12/22 V22 stated they try to do them every morning. When asked if she saw R5 when she was doing rounds on the morning of 10/12/22, V22 stated, "No, he was probably already up."

On 10/27/22 at 10:52 AM, V6 (CNA) stated she got report at the nurse's station on the morning of 10/12/22. When asked if they did rounds and saw each resident V6 stated they did not. When asked if anyone reported R5 falling V6 stated, "No."

On 10/27/22 at 9:37 AM, V20 (LPN) stated she was not aware of R5 falling on the night of 10/11/22. V20 stated it may have been the other nurse working that night.

On 10/27/22 at 12:23 PM, V1 (Administrator) and V2 (DON) stated the only two nurses working on the night of 10/11/22 was V20 and V15.

On 10/20/22 at 9:52 AM, V15 (LPN) stated R5 didn't fall when she was working.

R5's medical record does not document an incident report, interventions, supervision, or monitoring related to a fall on 10/11/22 around 8:00 or 9:00 PM.

On 10/27/22 at 12:23 PM this surveyor informed V2 (DON) of the report of R5 falling out of his recliner on 10/11/22 at approximately 8:30 PM. V2 was not aware of it prior to being informed by this surveyor. V2 stated she didn't think R5 would be able to get back into his recliner without

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S9999	Continued From page 55 assistance. On 10/26/22 at 9:41 AM, V1 (Administrator) stated R5 couldn't have been in the floor from 2 am to 6 am like R5 said. V1 stated he knew he didn't have his call light on because he said it was in his hand and then he said it slid out of his hand and the video shows people walking up and down the hallway. When asked if I could view the video V1 asked if it would help his case. This surveyor stated I didn't know if it would since I hadn't seen the video. On 10/27/22 at 2:15 PM this surveyor observed the video of R5's hall on with V1 and V2 present. The door to R5's room was not clearly visible as the camera was facing the opposite wall and there was something obstructing the direct view of R5's doorway. At 5:48 AM there was a CNA (possibly V21) who entered the hallway and got linens off the cart in the hallway. V21 then entered either R5's room or the room next to it. V21 then exited the room with dirty linens and placed them in a receptacle. On this same date and time V2 (DON) stated R5 had been incontinent. R5's nurses notes reviewed from 10/07/22 to 10/13/22 document R5 is continent of bowel and bladder. V1 (Administrator) walked down the hall on live video to show this surveyor V21 entered R5's room. It was not clear on the live camera feed which room V1 was entering. Based on the view available from the video it is not possible to determine if V21 entered R5's room. This indicates R5 had two falls one on 10/11/22 and a second one on 10/12/22 with no documentation of intervention, assessment, or follow up of the fall on 10/11/22. This also indicates R5's family requested a CT scan to be	S9999		

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S9999	Continued From page 56 done to ensure the brain bleed he acquired in the motor vehicle accident prior to his stay at the facility had not worsened. The facility did not facilitate the CT scan being done to ensure no further injuries before or after the falls. 3. R4's Admission Record dated 10/20/22 documents R4 was admitted to the facility on 8/5/2020 with diagnoses that include dementia, osteoarthritis, abnormal posture, unsteadiness on feet, and hypertension. R4's MDS dated 9/8/2022 documents R4 has a BIMS score of 06, which indicates R4 has a severe cognitive impairment. R4's Fall Risk Assessment dated 8/5/2020 documents a score of 14, which indicates R4 is at risk for falls. R4's facility Progress Notes documents the following: 10/01/22 at 8:55 AM "Resident (R4) found on floor next to bedroom, small skin tear w/ (with) hematoma on mid forehead assessed resident and residents ROM (range of motion). Assisted resident to bedside with help. Resident does not complain of any pain at this time. Tried to contact residents contact but unable to do so. Neuro (neurological) checks initiated." 10/01/22 10:49 PM "Resident (R4) has bruising around eyes, bright purple in color. Nose is sl (slightly) swollen. Denies any discomfort. Resting quietly with eyes closed." 10/3/22 10:35 AM "Residents (R4) face has discoloring both eyes are purple, and bruising runs down to jaw line. Resident has a hematoma to forehead that is sore when she touches it, she says, but denies any pain when asked if she hurts anywhere. Resident is alert and oriented but does not remember her fall, she says."	S9999		

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S9999	Continued From page 57 R4's Fall IDT Note dated 10/03/22 documents, "Nurse walked into room and noticed resident was on floor next to bed. Resident had a hematoma on frontal lobe of forehead. Nurse went and got Nurse to help her access resident. Upon arrival this nurse noticed hematoma and small amount of blood and resident laying on right side. Resident reported no pain in neck or extremities. ROM (range of motion) equal in all four extremities. Resident no (sic) on blood thinners at this time. No other injuries noted. Root Cause of Fall: Resident reported that she fell out of bed onto floor. Intervention and care plan updated: Wedge cushion placed on both sides of bed to help keep resident from rolling out of bed." R4's undated Care Plan documents a Focus area of "R4 is at risk for falls related to dementia with cognitive impairment. Dx (diagnosis) osteoarthritis." Interventions documented are as follows: "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Follow facility fall protocol. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT (interdisciplinary team) as to causes." R4's care plan does not document the fall on 10/01/22 or the intervention of a wedge cushion being implemented. R4's Order Summary Report dated 10/20/22 with Active Orders as of 10/20/22 documents a physician order of Plavix (antiplatelet agent) 75 milligrams daily with a start dated of 2/15/21. The article published in 2021 at https://pubmed.ncbi.nlm.nih.gov/33294625/	S9999		

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S9999	Continued From page 58 documents, " Patients on antiplatelet agents (Plavix) with head trauma have a high rate of ICH (intracranial hemorrhage). Routine head CT is recommended. Patients infrequently developed delayed ICH. Routine repeat CT imaging does not appear to be necessary for all patients." R4's neuro checks were reviewed, and document neuro checks were done on 10/01/22 at 8:45, 9:00, 9:15, 9:30, 10:30, 11:00, 11:30 AM, 2:30 and 6:50 PM. R4's neuro checks were documented as done on 10/02/22 at 7:30 AM, 11:30 AM, and 7:30 PM, on 10/03/22 at 3:30 AM, 11:30 AM, and 7:30 PM, and on 10/04/22 at 3:30 AM and 11:30 AM. This indicates R4 did not have neuro checks administered per the facility policy four times in a 72-hour period. On 10/19/22 at 3:32 PM, R4 stated she didn't remember how she fell but she did fall out of bed and hit her head. R4 stated she ended up with two black eyes but couldn't remember anything else. R4 stated she wasn't afraid of anyone. On 10/21/22 at 1:55 PM, V2 (Director of Nurses) stated she was not sure why R4 did not have neurological checks (neuro) done per the facility policy. V2 stated the neuro checks should have been done. 4. R2's facility Admission Record dated 10/20/22 documents R2 was admitted to the facility on 3/11/2018 with diagnoses that include bipolar disorder, diabetes, hypertension, anemia, weakness, and lack of coordination. R2's MDS dated 8/24/22 documents a BIMS score of 13, which indicates R2 is cognitively intact.	S9999		

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APERION CARE FAIRFIELD	305 N.W. 11TH STREET FAIRFIELD, IL 62837

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S9999	Continued From page 59 R2's undated Care Plan documents a Focus area with an initiation date of 3/11/2018 of "I am at risk for fall/injury r/t (related to) weakness and tiredness." The interventions documented for this focus area are "6/11/18 Encourage resident to consume 75-100% of meals served, 3/11/2018 notify physician as needed of any changes." There are no fall interventions documented after 6/11/2018. R2's Fall Risk Assessment dated 10/07/22 documents a score of 05, which indicates R2 is not at risk for falls. The assessment documents R2 has not had any falls in the past 3 months. R2's Order Summary Report dated Active Orders as of 10/20/22, documents a physician order for Eliquis 5 milligrams twice daily with a start date of 7/28/22. On 10/20/22 at 9:25 AM, R2 stated he did have a fall at the facility one time. R2 stated he was in bed asleep and rolled a little too far and the next thing he knew he was on the floor. R2 stated facility staff were there quickly and checked on him and he didn't think he hit his head. R2's fall progress notes documents on 8/18/22 "R2 states he rolled OOB (out of bed) in his sleep, found on floor next to bed setting on his bottom. No limitations or deformities in ROM (range of motion), confusion noted "O2 sats (oxygen saturations) were abnormal. No injuries noted, states he did hit his head. O2 applied stats came up to 90% @ (at) 5L/NC (liters per nasal cannula) V4 (Physician) @ 1911 (7:11 PM) orders to just watch et (and) observe closely @ this time." R2's medical record did not document any further	S9999		

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S9999	Continued From page 60 follow up, neurological checks, or a fall investigation. On 10/21/22 at 1:55 PM, V2 (DON) stated she was aware R2 had fallen when this surveyor asked about it. V2 stated a "shift key nurse" (agency nurse) didn't put the information related to R2's fall on the right report so it didn't trigger them to follow up. V2 stated there were no neurological checks documented and no new interventions implemented to prevent future falls. The facility Fall Prevention Program dated 11/21/12 documents, "Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary." The facility undated Incident/Accident Reports policy documents "The Incident/Accident Report is completed for all unexplained bruises. Or abrasions, all accidents, or incidents where there is injury or the potential to result in injury, allegations of theft and abuse registered by residents, visitors or other, and resident to resident altercations. Procedure: An 'incident 'is defined as any happening, not consisted with the routine operation of the facility, that does not result in bodily or property damage. Physical or mental mistreatment (abuse-actual or suspected) of a resident is considered an 'incident' whether or not actual injury occurred. An 'accident' is defined as nay happening, not consistent with the routine operation of the facility that results in bodily injury other than abuse ....4. Documentation in nurses' notes is to include a. A	S9999		

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S9999	Continued From page 61 description of the occurrence, the extent of injury (if any), the assessment of the resident, vital signs, treatment rendered, and parties notified. b. A minimum of seventy-two (72) hours (longer if indicated) of documentation by all three shifts on resident status after the incident. Vital signs, mental and physical stated, follow-up, tests, procedures, and findings are to be documented. 5. All incident/accident reports are reviewed, signed, and investigated by: a. The Administrator; and b. The Director of Nursing or the Assistant Director of Nursing." The facility undated Neurological Assessment policy documents, "Purpose: 1. To establish a baseline neurological assessment. 2. To recognize neurological trends and any changes in resident's condition. 3. To provide an evaluation tool for reference when evaluating the resident's neurological status. Neurological assessments should be performed as follows for a 72-hour period, unless otherwise ordered by the attending physician. 1. Every 15 min (minutes) x (times) 4 = 1 hour, 2. Every 30 min x 2 = 1 hour, 3. Every 4 hours x 6 =24 hours, 4. Every 8 hours x 6 = 48 hours. 3. Assess the resident's vial signs including a. Blood Pressure, b. Apical heart rate and rhythm, c. Radial and femoral pulses, bilaterally, d. Respiratory rate and rhythm, e. temperature ...13. Complete documentation of neurological assessment in the resident's clinical record." (B) 3/3 300.610a) 300.1210b) 300.1210d)1) 300.3240a)	S9999		

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S9999	Continued From page 62 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. Section 300.1210 General Requirements for Nursing and Personal Care 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 administered. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or	S9999		

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S9999	Continued From page 63 agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations were not met as evidenced by: Based on interview and record review the facility failed to transcribe physician orders to ensure blood glucose monitoring, acquisition, and administration of insulin in accordance with the prescriber's order on two separate facility admissions for 1 of 5 (R5) residents reviewed for administration of insulin. This failure has the potential for R5 to develop ketoacidosis which could result in coma and possible death. Findings Include: R5's facility Admission Record with a print date of 10/20/22 documents R5 was admitted to the facility on 10/07/2022 and discharged on 10/14/22 with diagnoses that included Type 2 Diabetes without complications. R5's MDS (Minimum Data Set) dated 10/8/22 documents a BIMS (Brief Interview for Mental Status) score of 15, which indicates R5 is cognitively intact. R5's regional hospital after visit summary with hospital stay dates of 10/04/22 to 10/7/22 includes the following medications on the "medication list," Tresiba inject 52 units into the skin daily and NovoLog 100 unit/ml inject into skin 3 times daily. R5's regional hospital records document under Scheduled meds sorted by name an order for Humalog three times daily before meals if blood glucose is "150-169 give 1	S9999		

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S9999	Continued From page 64 unit, 170-189 give 2 units, 190-209 give 3 units, 210- 229 give 4 units, 230-249 give 5 units, 250-269 give 6 units, 270-299 give 7 units, and if BS (blood glucose) greater than or equal to 300, give 8 units and recheck BS at next ordered time. If BS remains consecutively greater than 300 at next scheduled recheck call MD (physician)" R5's regional hospital record documents under Basic Metabolic Panel that R5's blood glucose level was 176 on 10/07/22. There is a noted discrepancy in R5's hospital discharge orders that lists both Novolog and Humalog as the fast acting insulin to be administered via sliding scale. Since these orders were never implemented at the facility, it was never clarified which fast acting insulin was correct. R5's Progress Notes document on 10/08/22, R5 was transferred from the local dialysis center to the local emergency room for evaluation of chest pain. R5's progress notes document R5 was admitted to a regional hospital. R5's progress notes document R5 was discharged from the regional hospital back to the facility on 10/10/22. R5's regional hospital records, under Patient Care Orders, include physician orders on 10/10/22 for Tresiba 52 units inject into skin daily and Humalog three times daily before meals with the following schedule documented, "150-189 - 1 unit, 190-299 - 2 units, 230-269- 3 units, 270-299 - 4 units, if blood glucose is greater than or equal to 300, give 5 units and recheck BS at next ordered time. If BS remains consecutively greater than 300 at next scheduled recheck, call MD." R5's Order Summary Report dated "Active orders as of 10/13/2022" do not document physician orders for insulin or blood glucose monitoring from 10/07/22 until 10/13/22.	S9999		

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S9999	Continued From page 65 R5's Medication Administration Record (MAR) dated 10/01/22 to 10/31/22 does not document an order to administer sliding scale insulin, Tresiba insulin, or to monitor blood glucose levels from 10/07/22 to 10/13/22. R5's facility progress notes document on 10/12/22 7:30 AM, "Resident (R5) had an un-witnessed fall 10/12/22 6:30 AM. Location of Fall: Resident Room, Resident attempted to arise from recliner to take self to bed. Resident slid from recliner to the floor. Resident stated no injuries were obtained. On 10/12/2022 6:30 AM Assessment: Witnessed Fall- Did not strike head; Neurological checks not indicated. Alert and oriented to time, person, place, and situation. No changes in range of motion from normal baseline. No injuries observed. Actions Taken: Multiple staff assisted resident from floor to recliner. Full body assessment completed with no findings of any new areas. Daughter insisted that resident be seen in the ER. Resident was seen in ER with a full work up completed, IVF (Intravenous fluids) administered, labs drawn, and CT (computerized tomography) of head completed. Resident returned to the facility with daughter escorting him. Report given by ER nursing staff and no areas of concern noted. No findings all test negative. No new orders given at time to discharge from emergency room. Vitals: Hypotension: medications reviewed, and areas of concern noted R/T (related to) consistent with low blood pressure. V4 (Physician) notified and full admission assessment completed. V4 (Physician) will continue to monitor." R5's local hospital records dated 10/12/22 documents under Assessment, " Patient (R5) brought to ER (emergency room) from (name of	S9999		

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S9999	Continued From page 66	S9999		

facility) by family member who reports patient fell at nursing home this morning. Patient was in floor for approx (approximately) 4 hrs (hours) and is unsure if he slid off the bed or had stood up and fell. Patient is slightly confused and family states that patient has been declining cognitively since Sunday. Family reports she requested nursing home have a CT (computerized tomography) of the head done but the order had never been obtained." Under additional history R5's hospital record documents, "AMS (altered mental status) x (times) 2 days. Recent Subarachnoid bleed from MVC (motor vehicle crash) 10/3/2022, possible fall early this AM."

R5's local hospital Lab Results Summary dated 10/12/2022 documents a blood glucose level of 273 with the normal range listed as 65-110.

On 10/19/22 at 9:32 AM, R5 stated the facility staff didn't stick his finger (blood glucose monitoring) or give him his insulin. R5 stated his blood sugar was a little high while he was at the facility. When asked what symptoms he would have when his blood sugars were elevated R5 stated, dizziness and weakness.

On 10/18/22 at 4:00 PM, V5 (Family Member) stated R5 was admitted to the facility for physical therapy after a hospital stay for a motor vehicle accident with a subsequent brain bleed. V5 stated on 10/08/22 R5 was re-admitted to the hospital from dialysis for evaluation for complaints of chest pain. V5 stated on 10/10/22 she transported R5 back to the facility and delivered his hospital discharge orders to the facility staff. V5 sated on 10/11/22 she stopped to visit R5 on her lunch break and an unknown CNA mentioned he seemed a little confused. V5 stated that was not normal for R5 but he sometimes gets really

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tired after dialysis. V5 stated after sitting with R5 she determined R5 did not seem himself intermittently throughout her visit. V5 stated she asked R5 if he had been getting his blood sugars checked and he said he had not. V5 stated she asked R5 if he had been getting his insulin and he wasn't sure. V5 stated she spoke with the nurse (believed to be V11) and told V11 about R5's Dexcom reader in his room and V11 stated he would share it with the other nurse's. V5 stated on 10/12/22 she was notified by a family member R5 had fallen. V5 stated she spoke with V2 (DON) on the phone on 10/12/22 and asked her if R5 had been receiving his insulin and V2 stated they had been checking his blood sugar with R5's "reader" and had been administering R5's insulin. V5 stated after she got off work she asked the facility if they had gotten the CT scan she had requested to ensure R5's intermittent confusion and falling were results of the brain bleed worsening and they had not so V5 signed R5 out of the facility and took him to the local emergency room for evaluation. V5 stated upon returning to the facility she reported to the nurse working that R5 needed his insulin and the nurse (V14) stated R5 did not have orders for insulin. V5 stated she went home and got R5's insulin to administer to him. V5 stated R5 administered his insulin himself as his blood sugars were over 300. V5 stated V14 found R5's hospital discharge orders from the regional hospital. V5 stated around midnight V14 came to R5's room and reported she had found R5's insulin orders and R5 had not been administered insulin since his admission to the facility on 10/07/22. V5 stated she asked V2 on 10/13/22 why she had told her R5 had been getting his insulin when in fact he had not and V2 stated the nursing staff had told her he was. V5 stated then V2 told her R5 did have blood glucose monitoring ordered and V5 told V2 that ordered

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S9999	Continued From page 68 was put in at midnight on 10/12/22 after it was determined they weren't being done. V5 stated at this point R5 had returned to his normal baseline since his blood sugars were back within normal range. R5's FreeStyle Libre 2 AGP Report documents R5's blood glucose readings and was obtained from V5 (Family Member) on 10/20/22 at 7:06 AM. This report dated 10/7/22 to 10/13/22 documents R5's blood sugar reading on 10/07/22 at approximately 8 PM as being 226. There are no blood sugar readings documented for 10/08, 10/09, 10/10, and 10/11/22. The report documents on 10/12/22 beginning at 6:00 PM and ending at midnight, R5's blood sugars were 238, 241, 266, 298, 307, 322, 312, 275, 252, 248, 240, and 215. R5's blood sugars on 10/13/22 beginning at 2:00 AM and ending at 12:00 PM are 192, 182, 180, and 154. This indicates R5's blood sugars were as high as 322 before being administered insulin on 10/12/22 and down to 154 after getting insulin. On 10/19/22 at 1:15 PM, V11 (LPN/Licensed Practical Nurse) stated he provided care for R5 one day (unable to recall which day). R5's MAR (Medication Administration Record) dated 10/1/22 to 10/31/22 documents V11 signed off as administering medications on 10/11/22. V11 stated he knew R5 had the Dexcom (blood glucose monitor/reader) because V5 (daughter) had told him it was there, and some nurses were having issues using it. When asked if he administered insulin to R5, V11 stated he didn't recall giving R5 any injections. On 10/20/22 at 6:45 AM, V14 (LPN) stated she worked at the facility on 10/12/22 and provided care to R5 when he returned to the facility from	S9999		

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S9999	Continued From page 69 the emergency room on this same day. V14 stated when they (R5 and V5) returned from the emergency room they told her they had stopped at the cafeteria and eaten so R5 would need his insulin. V14 stated she informed them she didn't have physician orders for R5 to receive insulin. V14 stated V5 gave her R5's sliding scale that he had been following prior to admission to the facility. V14 stated she reviewed R5's admission paperwork/orders and located the physician orders for insulin. V14 stated the facility did not have the type of insulin R5 had ordered, so V5 provided R5's home insulin for administration, until it could be obtained from the pharmacy. On 10/19/22 at 1:35 PM, V12 (LPN) stated she only provided care one day while R5 was at the facility. V12 stated it was the last day R5 was at the facility (10/14/22), before being transferred to another Long-Term Care Facility. V12 stated she didn't administer R5's insulin because R5's daughter administered it. When asked if R5 had insulin in the medication cart, V12 stated, he didn't. On 10/20/2022 at 1:33 PM, V16 (Pharmacist) stated R5 did not have an order for insulin and /or insulin delivered to the facility from the pharmacy until 10/13/22. R5's Order Summary Report "Active Orders as of: 10/13/2022" documents the following orders with start date of 10/13/22; blood glucose check before meals and bedtime as needed, blood glucose check before meals and bedtime, Humalog Kwik pen 100 unit/ml (milliliter) (this order has pending confirmation documented next to) inject as per sliding scale if 0-70 = 0 unit, if 71-100 = 4 units, if 101-150 = 8 units, if 151-200 = 12 units, if 201-400 = 16 units, subcutaneously	S9999		

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S9999	Continued From page 70 before meals, Novolog flex pen 100 unit/ml inject as per sliding scale before meals and bedtimes with the same sliding scale dosing as listed above, Tresiba 100 unit/ml inject 52 units subcutaneously in the morning. R5's Medication Administration Record (MAR) dated 10/01/22 to 10/31/22 documents an order for Tresiba Solution 100 unit/milliliter (ml) inject 52 units subcutaneously in the morning with a start date of 10/13/22 and the MAR documents it was administered on 10/13/22 and 10/14/22 at 8:00 AM. R5's MAR does not document Tresiba was administered on any other day during R5's stay at the facility. This indicates R5 did not receive Tresiba insulin as ordered on 10/08, 10/11, and 10/12/22. However, V5 reported self-administering R5's insulin on the night of 10/12/22. R5's MAR documents an order for NovoLog flex pen 100 unit/ml inject as per sliding scale if 0-70 =0 units, 71-100 = 4 units, 101-150=8 units, 151-200 = 12 units, 201-400 = 16 units inject subcutaneously before meals with a start date of 10/13/22 at 5:00 AM. R5's MAR documents R5's blood sugar was 180 and 12 units of NovoLog insulin was administered on 10/13/22 at 5:00 AM. R5's MAR does not document R5 received any other doses of sliding scale insulin from day of admission on 10/07/22 until day of discharge on 10/14/22. R5's MAR documents an order for blood glucose checks before meals and at bedtime with a start dated of 10/13/22 at 5:00 AM. R5's MAR documents the following blood glucose results 10/13/22 5:00 AM - 180, 10/13/22 11:00 AM 154, 10/13/22 4:00 PM -131, 10/13/22 8:00 PM - 210, 10/14/22 5:00 AM - 161, 10/14/22 11:00 AM -162. This indicates R5 should have received sliding	S9999		

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S9999	Continued From page 71 scale insulin on 10/13/22 at 11:00 AM, 4:00 PM, and 8:00 PM and on 10/14/22 at 5:00 AM and 11:00 AM. R5's MAR does not document the sliding scale insulin was administered as ordered. On 10/21/22 at 9:45 AM, V2 (DON) stated there were insulin orders for R5 on his hospital discharge orders, but it was confusing because some of it was handwritten in. V2 stated if it isn't handwritten by the physician, then it throws her off. When asked what her expectation would be, in that situation, V2 stated she would expect the nursing staff to call the physician and clarify the orders. When asked if she did a med error report V2 stated, "No, I will." At 1:55 PM on this same date V2 stated the nurse responsible for reviewing and transcribing R5's admission orders, no longer works at the facility. V2 stated she was made aware R5 had not received his insulin the day he came back from the hospital (10/12/22). V2 stated when she became aware of it, she reviewed the orders, and did an audit of each resident on insulin on 10/20/22. On 10/25/22 at 3:00 PM, V2 stated R5's medication administration record does not document R5 received sliding scale insulin as ordered by the physician. V2 confirmed the blood glucose checks were done as ordered and R5 should have received sliding scale insulin. V2 stated she would consider it a medication error and she would expect insulin to be administered as ordered. On 10/21/22 at 11:30 AM, reviewed R5's orders and administration records with V4 (Physician) which documented R5 should have received long-acting insulin as well as sliding scale insulin. V4 stated, "That is inexcusable." V4 stated he takes that very seriously. Reviewed with V4 what	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009815	A. BUILDING: _____ B. WING _____	C 11/14/2022

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S9999	Continued From page 72 R5's blood glucose levels (273) were when he was evaluated at the hospital and V4 stated he didn't think R5 not getting his insulin was a contributing factor for the fall. When asked what the potential negative outcomes are for a diabetic to not get insulin as ordered V4 stated, "Ketoacidosis, coma, and possible death." R5's undated care plan documents a diagnosis of Type 2 Diabetes Mellitus with no focus area or interventions documented related to the diagnosis. The facility Medication Variance Report dated 10/13/22 documents R5 had an order of Tresiba inject 52 units subcutaneously every morning related to Type 2 diabetes mellitus with the order date documented as 10/10/22. The variance report documents R5 didn't receive the medication. The report documents it was a missed order under transcribing error. The report documents V4 (Physician) was notified with no date or time of notification. The report documents "(V5) asked V14 (LPN) about insulin, which V14 found on orders but not in (electronic health record). Nurse (V14) then put all insulin orders in (electronic health record)." The report documents no harm with "circumstances or events have capacity to cause event," marked. The report documents the involved staff person was educated. The facility Medication Errors and Adverse Drug Reactions policy dated 11/7/2012 documents, "Purpose: 1. To safeguard the resident. 2. To identify causes and prevent future errors. 3. To provide guidelines for reporting and recording. General Guidelines: 1. All medication, treatment errors, and drug reactions must be reported promptly. Notify the attending physician or	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 73 Medical Director if the attending physician is not available. The Medication Error report is to be given to the Director of Nursing during or before the end of the shift for follow up. A detailed account of the incident must be recorded in the resident's medical record. Documentation should be factual and should not contain words such as "error" or "incident" Just state the facts. Documentation should include a. The time and date of the incident b. The name, strength, and dosage of medication administered c. The resident's reaction to the medication d. The condition of the resident e. Any treatment administered, and f. The date and time the physician and family was notified and his/her instructions. 4. Residents receiving incorrect medication or having a drug reaction should be observed as needed. Any change in the resident's condition will be reported to the physician and Director of Nursing ..." The facility Medication Administration Policy dated 1/1/2015 documents under, "II. Administration of Medications. Medications must be administered in accordance with a physician's order, e.g., the right resident, right medication, right dosage, right route, and right time." (B)	S9999		