Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004733	A. BUILDING: ______ B. WING ______	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY LINCOLN PARK	1366 WEST FULLERTON AVENUE CHICAGO, IL 60614

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S 000	Initial Comments COMPLAINT INVESTIGATION: 2385754/IL161958	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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.

These regulations were not met as evidenced by:

Based on interview and record review, the facility failed to supervise a cognitively impaired resident (R8) who is at risk for falls and has a history of falls from having repeated falls; failed to ensure that a licensed staff member assesses a resident who has fallen prior to moving the resident; failed to create and implement fall prevention interventions; and failed to follow their facility's fall policy and procedure in a total sample of 10 residents. As a result, R8 fell and sustained a sub capital left femoral neck fracture that required left hip hemiarthroplasty surgery.

Findings include:

R8's Admission Record, documents, in part, diagnoses of dementia, traumatic subdural hemorrhage, cognitive communication deficit, chronic obstructive pulmonary disease, hypertension and history of falling.

R8's Minimum Data Set (MDS), dated 5/3/23, documents, in part, a Brief Interview for Mental

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S9999	Continued From page 2 Status (BIMS) score of 3 which indicates that R8 has severe cognitive impairment. R8's Functional Status for walk in room (how resident walks between locations in his/her room) and walk in corridor (how resident walks in corridor on unit) is coded for a resident's performance of "supervision - oversight, encouragement or cueing." R8's Fall Risk Screen, dated 5/2/23, documents, in part, that R8 is at risk for falls with a history of falls within the last six months as "1-2 times." Fall report, titled "Incidents by Dates," with date range of 4/1/23 to 7/19/23, documents, in part, that R8 had two fall incidents: 7/6/23 at 10:23 am and 7/12/23 at 2:30 pm. R8's hospital radiology results, dated 7/13/23, from X-ray of left hip, pelvis, and femur show "sub capital left femoral neck fracture with half shaft width superior migration of the distal fracture fragment." On 7/24/23 at 12:05 pm, V15 stated that R8 is alert, walks around, will frequently change clothes throughout the day, and will have a "full blown conversation that makes sense" then will be confused and is going to get on the bus. V15 (Licensed Practical Nurse, LPN) stated that on 7/13/23, V15 stated, "I (V15) came in and was doing my med pass. (R8) was sitting on the bed, and I am used to seeing (R8) up walking. I told (V9, Certified Nursing Assistant, CNA) that R8 needed to be changed because R8 was sitting with R8's clothes half off." V15 stated that V9 went into R8's room to change R8, and then V9 reported to V15 that R8 won't stand up for V9's care and is in pain. V15 stated that V15 went to assess R8 and asked where the pain was, and	S9999		

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R8 was pointing to R8's left side. V15 stated that R8 said repeatedly, "I (R8) can't get up." V15 stated that V15 notified V21 (Nurse Practitioner, NP) who was in the facility. V15 stated that V21 and V15 went to R8's room together, and V21 assessed R8. V15 stated that when V15 assisted with removing R8's pants, R8 had left hip swelling, and when touching R8's left hip, R8 said, "Yes, it hurts right here." V15 stated that V21 ordered an X-ray of R8's left hip. When asked about supervision of R8 for fall prevention, V15 stated, "Everybody should do that. It depends on the time of the day. How many CNAs we have. I (V15) am passing meds. I can't monitor everyone."

On 7/13/23 at 10:50 am, V15 documented in R8's electronic medical record (EMR) in a Health Status/Progress Note, "During med pass (R8) c/o (complained/of) pain to left hip. Head to toe assessment done, and when touching left side of hip (R8) stated that hurts right there. Call was placed to (V21, NP) to inform of (R8) c/o pain and stating it hurts when (V15) asked to complete ROM to left leg. PRN (whenever needed) order for (Acetaminophen) was given. (V21) came to assess (R8) and after assessment (NP) ordered STAT X-ray of L (left) hip."

On 7/24/23 at 12:36 pm, V21 (NP) stated that R8 is confused, alert to person, is social on the unit speaking to peers and employees, and wanders, but is redirectable. V21 stated that V21 rounds on residents in the facility five days a week, and if a resident would have a fall incident or change of condition while V21 was in the facility, V21 stated, "I (V21) would see them that day." When asked if on 7/12/23, was V21 notified about R8's fall incident that occurred on 7/12/23, and V21 stated, "No. I (V21) was called by (V15) on

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7/13/23. (V15) called and said that (R8) was not (R8's) self and having pain. Not able to ambulate. This was an acute change." V21 stated that V21 went to R8's bedside to examine R8 and that V9 (CNA) and V15 (LPN) were there. V21 stated that R8 was in pain, rubbing R9's left hip and could only move R8's left leg a little bit while complaining of pain. V21 stated that V21 questioned aloud if R8 had fell again? V21 stated that V9 (CNA) said, '(R8) did fall yesterday.' I (V21) was never notified of that and that's why I got X-rays." V21 stated that V21 immediately reported not being notified of R8's fall from 7/12/23 to V24 (Assistant Director of Nursing, ADON #2), and that V24 came up to R8's floor to speak with V21 who said that V24 was aware of R8 complaining of pain on 7/12/23 but was not aware of R8's fall on 7/12/23. V21 stated, "I (V21) was not made aware of (R8's) pain on 7/12/23. If I would have, I would have seen (R8)." V21 stated that V21 had saw R8 in the morning on 7/12/23 (prior to the fall) and that R8 was not complaining of pain at that time. V21 stated that on 7/13/23 with R8's left hip pain and with V21 having knowledge now of R8 having a mechanical fall on 7/12/23, V21 ordered the stat X-ray of R8's left hip. V21 stated that on 7/13/23 at around 4:00 pm, V21 received a call from V15 (LPN) alerting V21 that R8's X-ray results showed a fracture, so V21 ordered R8 to be transferred to the hospital.

R8's Radiology Results Report for X-ray left hip (performed in facility on 7/13/23 at 12:11 pm and reported on 7/13/23 at 3:21 pm) documents, in part, "Findings: Mildly displaced sub capital left femoral neck fracture."

On 7/25/23 at 11:14 am, V11 (CNA) stated that R8 has dementia, is alert, is "not 100% there"

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S9999	Continued From page 5 mentally and that V11 assists R8 with getting dressed in the mornings. V11 stated that R8 will be dressed and then will be taking off R8's clothes to put on different or another resident's clothes. V11 stated that R8 is a "busy body." V11 stated that R8 will walk the unit, that R8 doesn't interact with activities (in dining room) and won't sit for long at the nurse's station before getting up and walking again. V11 stated that R8's gait is steady, but "not steady like ours," and when asked if R8 is a fall risk, V11 stated, "Absolutely. (R8's) a fall risk." When asked how does V11 prevent R8 from falling, V11 stated, "From time to time, I (V11) step out to monitor. When I am doing patient care and need to step out (to the hallway) to get something. It's kind of hard." V11 stated that on 7/12/23, V11 stated, "I (V11) was walking past (R8's) room, and I saw (R8) on the floor. We were passing lunch trays." V11 stated, "(R8) is by (R8's) roommate's (R10) bed. (R8) is long, and I saw(R8's) feet from the hallway. (R8) was laying on the floor on (R8's) back. I went in (to R8's room) and then out. I tiptoed out trying to find someone in the hall, and I found (V9, CNA) passing trays." V11 stated that V9 and V11 went into R8's room and that R8 was "laying on floor, reaching for us. We (V9, V11) assist (R8) up. We grabbed under (R8's) arms and supported (R8). And (R8) was walking. I was holding onto (R8) when (R8) walk back to bed. (R8) couldn't tell us what happened. (R8) sat on (R8's) bed. (R8) complained of pain on left side. We informed (V20, LPN) about the pain, and (V20) did assessment." V11 stated that V11 was R8's assigned CNA on 7/12/23 for the 7:00 am to 3:00 pm shift. V11 stated that when V20 was in R8's room (along with V9), V11 informed V20 that V11 found R8 on the floor. V11 stated that R8 stayed in bed on 7/12/23 for the remainder of the day shift. V11 stated that the procedure for when a	S9999		

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resident fall in the facility is to "inform the nurse let him or her proceed to check out the resident. Proceed to do what is necessary to get (resident) in a safe place on bed. It's the nurse's call." V11's statement about the facility procedure for not moving a resident prior to a nurse's assessment contradicts V11's actions on 7/12/23.

On 7/24/23 at 1:03 pm, V9 (CNA) stated that R8 is alert, confused and "walks around on (R8's) own." V9 stated, "(R8) does (R8's) own thing. You let (R8) do (R8's) own thing. (R8's) fine. We are just watching (R8)." V9 stated that R8 had a fall on 7/12/23 at lunch time while V9 was passing trays around 12:00 pm to 12:30 pm. V9 stated that V11 came for help from V9 because V11 found R8 on the floor. V9 stated that V9 and V11 went to R8's room and that V9 saw R8 laying on the floor next to the wall closest to R10's bed. V9 stated that R8 was reaching up, and V9 and V11 transferred R8, each under R8's arm, and walked R8 to R8's bed closest to the window. V9 stated that V9 heard V11 then tell V20 (LPN) about R8's fall and that V9 went to resume passing lunch trays to residents. V9 stated that about one hour later, V9 went back to R8's room to collect R8's lunch tray, and R8 was asking for pain medication. V9 stated that V9 informed V20 of R8's request for pain medication. V9 stated that the proper procedure when a resident fall is to inform the nurse to assess the resident. V9 stated that it was "impulse" that V9 moved R8 from the floor on 7/12/23 prior to V20 assessing R8. V9 stated that for the day shift on 7/13/23, V9 was assigned to R8, and was getting R8 dressed for the day. V9 stated that V9 was trying to get R8 to stand from the bed position and that R8 "completely couldn't stand" and that R8's left hip was hurting. V9 stated that V9 informed V15 (LPN) of R8's pain, not allowing V9 to dress R8,

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and R8 not being able to stand. V9 stated that V9 and V15 returned to R8's room to check on R8. V9 stated that V21 (NP) then came to R8's bedside, and V9 let V15 and V21 know about R8 being found on the floor on 7/12/23.

On 7/25/23 at 10:00 am, V20 (LPN) stated that V20 primarily works R8's floor where residents have dementia, Alzheimer's, are confused and wander. V20 stated that V20 is familiar with R8 and that R8 has dementia, is alert, "wanders everywhere." V20 stated that V20 instructs the CNAs to monitor R8 and to "make sure that we see (R8) all the time. But it's hard to do when we have short staff." V20 stated that R8 is a fall risk resident, and R8 is "constantly moving, won't stay in chair, won't stay in room." When asked if R8 has had a fall incident when V20 was working in the facility, V20 stated, "No, never that I (V20) can recall on my shift. No one reported to me that (R8) fell. In my shift, (R8's) at risk, and I would endorse to the other nurse if (R8) had fallen. (R8) had pain, and I reported to nurse to monitor (R8) after pain medication." When asked about V20's documentation in R8's EMR dated 7/12/23 about R8's pain, V20 stated that V9 and V11 (CNAs) informed V20 that R8 was complaining of pain. V20 stated that this was round 2:00 pm on 7/12/23 and that R8 was in bed. V20 stated that V20 assessed R8, asking R8 where the pain was, and that R8 was pointing to R8's left hip and lower back and was asking for pain medication. V20 stated that V20 assessed R8's skin near R8's left hip (with assistance from CNA (V9) to pull down elastic waistband pants) and that V20 had R8 move R8's left leg. V20 stated that when R8 moved R8's left leg, R8 was "guarding" the left hip, and V20 "did stand (R8) up and sit down" but that R8 didn't "go anywhere else." V20 stated that R8 cannot tell V20 a number of the pain scale, so

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V20 scored R8's pain as a 4 out of 10 scale and administered Acetaminophen to R8 for pain. V20 stated that on 7/12/23 around 6:30 pm to 7:00 pm, V20 reassessed R8's pain level and that R8 stated that R8 was fine. When asked about R8's activity on 7/12/23 from 2:00 pm to 7:00 pm, V20 stated, "I (V20) didn't lay eyes on (R8) and to be honest. I didn't know if (R8) was in (R8's) room or the activity room. CNAs are monitoring (R8). They will let me know." V20 stated that R8's pain was "just normal" and that V20 did not inform V21 (NP) of R8's left hip pain on 7/12/23. When asked about V20's late entry documentation (for R8's pain on 7/12/23, V20 created a progress note on 7/14/23), "They just remind you. (R8) may have some fall." V20 stated that V12 (ADON #1/Fall Coordinator) reminded V20 to perform documentation for R8 in R8's EMR. V20 stated that V20 documented R8's fall incident charting documents on 7/13/23, and V20 documented a "recent fall" for R8. V20 stated that on 7/13/23, V15 (LPN) reported to V20 (LPN) that R8 had a fall on 7/12/23, so V20 then connected R8's left hip pain to an unwitnessed fall. When asked V20 to describe a resident's change of condition, V20 stated that if a resident "cannot walk, cannot lie down, crying out, blood pressure out of limits," then V20 will notify the in-house nurse practitioner. V20 stated, "That's my job, my priority is their health. Make sure they (residents) are well taken care of."

On 7/14/23 at 5:00 pm, V20 (LPN) created (documented) this late entry "Health Status/Progress Note" with effective date of 7/12/23 at 6:00 pm, "(R8) received at 9:00 am up and about in the hallway with good steady gait. Alert, oriented x 1-2. Quiet, calm with periods of confusion noted. Redirected as needed. Has good appetite for breakfast and adequate fluids

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intake. Compliant with all due meds without on towards side effect. Needs one staff assist with ADL's (activities of daily living). Vital signs are within normal range. Approximately around 2pm, (V20) informed by (V9, V11, CNAs) that (R8) is complaining of pain. (V20) assessed (R8). (R8) sitting on bed, verbalized that (R8) had pain on (R8's) left side and back pain. Vital signs stable, able to move (R8's) lower and upper extremities without any discomfort. (R8) was medicated with (Acetaminophen), PRN, and was relieved with positive result in an hour. 7:00 pm: F/U (follow/up) (R8) pain currently. (R8) verbalized (R8) was relieved and remain verbalize on (R8's) baseline. (R8) return to (R8's) baseline until end of shift. Endorse to 2nd shift nurse 7p-7a to check and monitor (R8)."

R8's Fall Risk Screen (7/13/23 at 6:58 pm), R8's SBAR (Situation, Background, Assessment and Recommendation) Report (7/13/23 at 6:52 pm), R8's Follow Up/Monitoring: Falls (7/13/23 at 6:54 pm) and Pain Evaluation (7/13/23 at 6:36 pm) were documented by V20 for R8's left hip pain and unwitnessed fall on 7/12/23.

On 7/25/23 at 1:34 pm, V12 (ADON #1/Fall Coordinator) stated that R8 has dementia, is a wanderer and walks freely on R8's locked unit. V12 stated that R8's fall interventions include staff keeping R8 "within their vision" and being "mindful of where (R8) is throughout the shift." V12 stated that a resident's care plan for fall prevention is done on admission, quarterly and when a resident has a fall occurrence. V12 stated that V12 performs an investigation when a resident has a fall incident to determine the "root cause to see what happened." V12 stated that V12 will then update the resident's care plan with a new intervention to "prevent a fall from

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S9999	Continued From page 10 happening again. To prevent further falls." V12 stated that fall risk screenings are done on admission, readmission, quarterly and when a resident falls. V12 stated that the rescreening when a resident fall is to see if functional status has changed, medication have change or resident may require an assistive device. V12 stated that the nurse will document in the resident's EMR of a fall occurrence which triggers 5 risk management forms to complete: fall risk screen, fall event form, pain risk screen, SBAR, and follow up monitoring. V12 stated that the follow up monitoring for a resident post fall occurrence is done for 72 hours (3 days). When asked how a nurse can document follow up monitoring after a resident's fall when the follow up monitoring is backdated greater than 3 days from the fall incident, V12 stated, "It should be in the forms if they (nurses) are following procedure. It doesn't transfer into the progress notes." V12 stated that if a CNA finds a resident on the floor, the nurse is to do an assessment prior to moving the resident. V12 stated, "To ensure that it's safe to transfer, to safely transfer to wheelchair or bed." V12 stated that it's important not to move a resident that has fallen without a nurse assessing the resident because the resident may have hit his/her head, have pain to neck or down the back, or have broken legs. V12 stated that the nurse will assess the resident who has fallen with checking range of motion (ROM) of extremities, searching for bony prominences, severe pain on palpation, and leg length shortening. V12 stated that the purpose of having a nurse assess a resident who has fallen prior to moving the resident, "To have a trained person with a license and education. Passed their state boards. Qualified to assess the resident for safety." When asked if a nurse assessed R8 prior to moving R8 who was on the floor on 7/12/23, V12 stated,	S9999		

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SYMPHONY LINCOLN PARK	1366 WEST FULLERTON AVENUE CHICAGO, IL 60614

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"That did not occur. They (V9, V11, CNAs) just assisted (R8) up. Not part of policy. What a CNA should do is notify the nurse prior to getting resident up and moving resident." V12 stated that it's important for nurses to timely document a resident's fall incident in the EMR because "it's safety to resident. If nurse not doing follow up with risk management, it could lead to delay of care. It's for our policy."

On 7/13/23 at 3:17 pm, V12 (ADON #1/Fall Coordinator) documented, in part, in an Interdisciplinary Note, "Incident: (R8) found lying on the floor at the bedside on 7/12/23. Root Cause: (R8) lost (R8's) balance while transferring from the bed and fell to the ground."

On 7/24/23 at 12:36 pm, V21 (NP) stated that on 7/6/23, "I (V21) was on the unit. I was talking to (V15, LPN). (V15) was down the corridor (hallway). (R8) was seated in a regular chair facing the desk (at nurse's station). I was walking towards that area. Out of my periphery of my eyes, I see (R8) attempting to get out of the chair. (R8) seemed to loss balance and fell onto two knees. It was in hallway in front of one that leads to elevator." V21 stated that V21 was walking towards the nurse's station when V21 observed R8 falling. When asked if there was any staff at nurse's station at that time, V21 stated, "I don't recall." When asked where V15 was at when R8 fell on 7/6/23, V21 stated, "(V15 was) at the med cart. A few rooms down the hallway back from where I come from." V21 stated that the time of R8's fall on 7/6/23 was around 10:00 am." V21 stated that V15 came to assist V21, and that R8 didn't have pain with V21's assessment. V21 stated that V21 performed a head-to-toe assessment, that R8 did not hit R8's head and that V15 and V21 performed a 2 person transfer

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to place R8 back into the chair. V21 stated that V21 informed V15 "to monitor (R8) and follow the facility's fall protocol." When asked about expectations of facility staff with notification of a resident's fall event, V21 stated, "I (V21) expect to be notified of a fall. At that point, with a previous fall on 7/6/23, it is indication (for R8) with the fall on 7/12/23 that I considered blood work and concern for UTI (urinary tract infection). Working up something other for potential sources leading to seeing if there's a functional decline for (R8). (R8) had a fall (7/12/23) with delay of treatment." When asked if R8 experienced harm with having an unwitnessed fall on 7/12/23, then R8 being moved after the fall by staff with complaints of pain, and V21 not being notified until 7/13/23 of R8's fall on 7/12/23 with pain complaints, "Yes. Additional harm." When asked what are V21's expectation of facility staff when a resident falls in the facility, "It's up to their protocol." When asked what are V21's expectation of facility staff to help prevent a resident like R8 (alert, confused, wandering with dementia) from falling, V21 stated, "I (V21) expect for any patient who has those behaviors to have frequent visual observation." V21 stated that R8 is at risk for falls.

On 7/24/23 at 12:05 pm, V15 (Licensed Practical Nurse, LPN) stated that R8 is confused and mobile who "walks everywhere." When asked if R8 is a fall risk resident, V15 stated, "Yes." V15 stated that on 7/6/23, V15 was in the hallway, and V21 (Nurse Practitioner) was at the nurse's station when R8 fell from a sitting position to the floor on R8's knees. V15 stated that V15 walked up the hallway and assisted V21 with transferring R8 back to the chair in the nurse's station. V15 stated V21 assessed R8 and performed R8's vital signs. V15 stated, "(V21) was basically doing

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everything. There wasn't anything else for me to do." When asked if there were any further orders from V21, V15 stated, "To monitor (R8)." When asked about when V15 documented in R8's electronic medical record (EMR) about R8's fall incident on 7/6/23, V15 stated, "I did documentation that day, yes." When this surveyor showed V15 the details of V15's documentation on 7/17/23 (11 days later) about R8's fall from 7/6/23, V15 stated, "I was so busy too. I forgot to do it. (V21) had documented everything. I probably forgot to put it in" on 7/17/23. V15 stated that V12 "said for me (V15) to put in my own note" and that V15 is responsible for R8's care documentation. I was busy, and it's not an excuse."

On 7/24/23 at 2:35 pm, V15 (LPN) stated that V15 did not notify V1 (Administrator) or V2 (Director of Nursing, DON) about R8's fall incident on 7/6/23. When asked who V15 notified in "management," V15 stated, "Nursing supervisor. The ADON." When asked if V15 notified either ADON for R8's fall incident on 7/6/23, V15 stated, "No, I don't recall."

On 7/17/23 at 4:50 pm, V15 (LPN) created (documented) this late entry "Health Status/Progress Note" with effective date of 7/6/23 at 10:48 am, "(R8) witnessed transferring without staff assistance from regular chair at nurse station. (R8) went to stand and lost (R8's) balance and fell down to the ground on (R8's) knees. (V21, NP) witnessed incident and was unable to catch (R8) in time before (R8) fell (to) the ground. Head to toe assessment performed by (V21) and nurse on duty (V15), no injuries were found. (R8) did not hit (R8's) head. (R8) is pleasantly confused. (R8) denies any pain and no s/s (signs/symptoms) of pain observed. Vital

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signs obtained and recorded: BP (blood pressure) 133/63, P (pulse) 77, R (respirations) 16, T (Temperature) 97.9, O2 (oxygen) Sat (saturation) 97% on room air. Neuro check performed. PERRLA (pupils equal, round, reactive to light and accommodation). (R8) was assisted up and into chair with 2-person extensive assistance without issues. (R8) remained comfortable in chair. (R8) remain at baseline mentation. No new orders received from (V21). Staff monitoring ongoing as per facility protocol. Family and management made aware."

On 7/6/23 at 3:21 pm, V21 (NP) documented, in part, in R8's Progress Notes, that "(R8) with fall this morning. (R8) was attempting to stand up from chair near the nurse's station, lost (R8's) balance and fell to ground, landing on knees."

On 7/17/23 at 4:38 pm, V15 (LPN) created (documented) this late entry "SBAR (Situation, Background, Assessment and Recommendation)" with effective date of 7/6/23 at 4:45 pm, "Reason for report: s/p (status/post) fall. New orders: Continue to monitor (R8) as per facility protocol."

On 7/17/23, V15 (LPN) created (documented) the additional fall incident forms for R8's fall on 7/6/23 including the "Follow Up/Monitoring," "Pain Evaluation," "Fall Risk Screen," and "Fall Event."

On 7/18/23 at 10:50 am, V12 (Assistant Director of Nursing, ADON #1/Fall Coordinator) stated that any time a resident fall in the facility, staff is to report the fall to V12. V12 stated that V12 ensures that the staff does the proper documentation and notifications. V12 stated, "I try to come up with an intervention to prevent a fall from occurring again."

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On 7/25/23 at 1:34 pm, V12 (ADON #1/Fall Coordinator) stated that V12 was notified about R8's 7/6/23 fall from V21 (NP) on 7/13/23 when R8's X-ray results showed a left femur fracture and was notified about R8's 7/12/23 fall on 7/13/23 by V15 (LPN). V12 stated that R8's risk management forms (7/13/23 risk management. I can't recall the date. If there is a incident for fall. Proper notification of md and family. It's safety to resident. If not follow up with risk management, it could lead to delay of care. It's for our policy." V21 stated that for R8's fall on 7/6/23, "I (V12) didn't update the care plan. I didn't know about it (R8's 7/6/23 fall)."

R8's Care Plan, dated 7/14/23, documents, in part, a focus of "(R8) had an actual fall on 7/12/23" with a goal of "(R8) will have minimized risk for fall(s)" with interventions (with created dates) as follows: "Educate staff making sure (R8) is in line of vision as much as possible *For Fall on 7/12/23* (created on 7/14/23);" "Increase purposeful rounds by staff (pain, positioning, potty, personal items and parting) *For Fall on 7/12/23* (created on 7/14/23);" "Refer to activities department for participation *For Fall on 7/12/23* (created on 7/14/23);" "Refer to skilled therapy (PT{physical therapy}/OT{occupational therapy}) *For Fall on 7/12/23* (created on 7/14/23);" "Get to know (R8) habits to anticipate (R8's) needs (created on 2/7/23);" and "Provide safe and secure surroundings (created on 2/7/23)." No interventions were documented in R8's care plan for the fall on 7/6/23.

On 7/25/23 at 12:32 pm, V24 (ADON #2) stated that on 7/13/23, V21 (NP) notified V24 about ordering R8 an X-ray for left hip pain and that V24 had no knowledge of R8's 7/6/23 fall and R8's

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7/12/23 fall.

On 7/25/23 at 2:12 pm, V2 (DON) stated that residents are assessed, identified for risk for falls and a care plan is developed to institute interventions to prevent falls. V2 stated that when a resident falls in the facility, the nurse will do a new fall risk screen, and the care plan is reviewed for existing interventions and to add, change or modify interventions to prevent a fall from happening again. V2 stated that the nurse will notify the provider (doctor or nurse practitioner), family member and the supervisor when a resident falls in the facility. V2 stated that either V2, V12 and V24 are to be notified in the supervisor team. V2 stated that V2 was notified of R8's 7/6/23 fall from V21 (NP) on 7/13/23 and was notified of R8's 7/12/23 fall on 7/13/23 from V12. V2 stated that a "follow up assessment is done after every fall" for monitoring of the resident for a change of condition after the fall. V2 stated that the nurse has the "whole shift" to document the fall incident forms, and that the follow up assessments (Follow Up Monitoring: Falls) is to be done "ideally for 72 hours." V2 stated that the follow up monitoring documentation "pops up" in the resident's EMR after a fall when the nurse initiates the fall incident forms in the EMR. V2 stated that the follow up monitoring won't appear in the forms in a resident's EMR if the nurse has not documented the fall occurrence. V2 stated that the nurse should document a fall incident if the nurse is aware of the fall, and it's the nurse's responsibility to notify the resident's family and practitioner. V2 stated, "It's part of our policy. Standard of care. They (nurses) are the one seeing the patient. Notification should be charted to communicate a change in condition. Change of condition is a fall." V2 stated that when a resident

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if found on the floor, the nurse is to assess the resident prior to moving because, "they (nurses) are trained, went to school for that, a standard of care." V2 stated that if a CNA moves a resident prior to the nurse assessing the resident on the floor, "Hypothetically if there is an injury, we could further comprise the injury that's why it's important to absolutely make sure that resident is not injured before moving resident to a comfortable position."

Facility policy dated February 2023 and titled "Falls Management," documents, in part, "General: This facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventative strategies, and facilitate as safe as environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as necessary. Responsible Party: RN, LPN, DON. Fall Prevention Guidelines for all residents upon Admission/Re-admission: 1. A Fall Risk will be completed on admission, readmission, and quarterly, with each significant change and after each fall. 2. Residents at risk for falls will have Fall Risk identified on the interim plan of Care with interventions implemented to minimize fall risk. Facility Guideline following a fall incident: 1. Evaluate the resident for any injury and alert the Health Care Provider and Emergency Contact. 2. Complete a fall event. This event includes the circumstances surrounding the fall, devices in use, full body observation for injury, pain, range of motion and neuro checks as needed. 3. A Fall Risk Screen is completed by the Nurse at the time of the fall and then reviewed by clinical leadership."

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S9999	Continued From page 18 Facility policy dated September 2022 and titled, "Safety and Supervision of Residents," documents, in part, "General: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Resident-Oriented Approach to Safety: 1. Our resident-oriented approach to safety addressed safety and accident hazards for individual residents. 4. Implementing interventions to reduce accident risks and hazards shall include the following: a. communicating specific interventions to all relevant staff b. assigned responsibility for carrying out interventions c. providing training, as necessary d. ensuring that interventions are implemented; and e. documenting interventions. 5. Monitoring the effectiveness of interventions shall include the following: a. ensuring that interventions are implemented correctly and consistently b. evaluating the effectiveness of interventions c. modifying or replacing interventions as needed; and d. evaluating the effectiveness of new or revised interventions. Systems Approach to Safety: 2. Resident supervision is a core component of the systems approach to safety." Facility policy dated May 2022 and titled "Dementia," documents, in part, "General: A resident who displays or is diagnosed with Dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being Treatment and Services: 4. The facility's approach to care for a resident living with dementia follows a systematic care process to ensure that residents' individualized dementia care needs are met."	S9999		

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Facility policy dated September 2016 and titled "Care Plans," documents, in part, "General: Each resident will have a care plan that is current, individualized and consistent with their medical regimen."

Facility job description dated 2003 and titled "Charge Nurse," documents, in part, "Purpose of Your Job Position: The primary purpose of your job position is to provide direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing Services or Nurse Supervisor to ensure that the highest degree of quality care is always maintained. Duties and Responsibilities: Ensure that all nursing personnel assigned to you comply with the written policies and procedures established by this facility. Fill out and complete accident/incident reports. Submit to Director as required. Chart all reports of accidents/incidents involving residents. Follow established procedures. Implement and maintain established nursing objectives and standards."

Facility job description dated 2003 and titled "Certified Nursing Assistant," documents, in part, "Purpose of Your Job Position: The primary purpose of your job position is to provide each of your assigned residents with routine daily nursing care and services in accordance with the resident's a

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