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
	IL6011571	A. BUILDING: ______ B. WING ______	C 10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCOLADE HC OF PAXTON ON PELLS	1001 EAST PELLS STREET PAXTON, IL 60957

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S 000	Initial Comments Investigation of Facility Reported Incident of 10-02-2023/IL165527	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)3)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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:	S9999		

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

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 are not met as evidenced by:

Based on observation, interview and record review the facility failed to timely report a resident fall to the resident's representative and physician for one (R1) of four residents reviewed for falls in the sample list of four. This failure resulted in R1 experiencing uncontrolled pain and a delay in treatment for R1's left hip fracture following a fall. The facility failed to complete post fall neurological assessments, complete post fall assessments/monitoring, identify a change in condition, and properly transfer a resident (R1) following a fall. These failures affect three (R1, R2, R3) of four residents reviewed for falls in the sample list of four. These failures resulted in R1 experiencing uncontrolled pain and a delay in treatment of R1's left hip fracture following a fall. The facility also failed to document a fall in the resident medical record and failed to prevent resident falls by failing to thoroughly investigate falls and implement fall interventions. These failures affect three (R2, R3, R4) of four residents reviewed for falls in the sample list of four. These failures resulted in R2 falling and sustaining a

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S9999	Continued From page 3 dislocated right ring finger. Findings include: On 10/23/23 at 9:40 AM R1 stated R1 had a recent fall while reaching for the remote, R1 slid from R1's wheelchair, and fell to the floor. R1 stated R1 told the staff that R1 had left hip pain and R1 had left hip surgery while at the hospital following R1's fall. On 10/23/23 at 1:39 PM R1 was lying in bed and had visible scarring to the left outer thigh, where staples had been removed. R1 had an incision with intact staples to the left hip. R1's Minimum Data Set (MDS) dated 9/27/23 documents R1 has moderate cognitive impairment. R1's Care Plan with revised date 10/23/23 documents R1 had a fall with injury, R1 is a new admission, has poor balance, poor communication/comprehension, and unsteady gait. This care plan includes an intervention dated 8/9/23 to "Observe/document /report PRN (as needed) x 72h (for 27 hours) to MD (Medical Doctor) for s/sx (signs/symptoms): Pain, bruises, change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation." R1's Nursing Note dated 10/2/23 at 11:42 AM, recorded by V19 Physician's Assistant, documents R1 had no pain or impaired range of motion to R1's legs. R1's Nursing Note dated 10/2/2023 at 4:15 PM documents R1 was heard calling for help from R1's room and V12 Registered Nurse (RN) found R1 sitting in the wheelchair without oxygen and without socks/shoes on. This note documents R1's buttocks was near the edge of the wheelchair and R1 was unable to scoot back. R1 complained of	S9999		

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left leg pain while V12 attempted to assist R1 in scooting back in the wheelchair which was unsuccessful and V12 lowered R1 to the floor onto R1's buttocks. This note documents R1 had good range of motion to all extremities and complained of left leg pain rated a 3 on a 10 scale. R1's Nursing Note dated 10/3/23 at 10:03 AM documents R1 complained of left hip pain rated a 10 on a 0-10 scale, and R1 was unable to bear weight related to R1's fall on 10/2/23. This note documents V11 Nurse Practitioner was notified, V11 gave orders to send R1 to the emergency room, and V20 (R1's Power of Attorney) was notified. There is no documentation that V11 Nurse Practitioner, V4 (R1's Physician), or V20 were notified of R1's fall or complaints of left leg pain prior to 10/3/23.

R1's Fall Incident Report/Investigation dated 10/2/23 documents R1's fall occurred at 3:15 PM. The section of this report titled "Agencies/People Notified" is left blank and does not document V4, V11, or V20 were notified of R1's fall.

R1's Left Femur x-ray dated 10/3/23 at 10:12 AM documents: "History: Pain after fall" and "Findings: Left intertrochanteric hip fracture with moderate comminution and significant angulation."

On 10/23/23 at 10:05 AM V12 RN stated on 10/2/23 between 3:00 PM and 4:00 PM V12 found R1 sitting on the edge of R1's wheelchair in R1's room, attempting to reach for a remote control. V12 stated V12 tried to scoot R1 back in the wheelchair and was unable, so V12 lowered R1 to the floor onto R1's buttocks with R1's legs extended outward. V12 stated R1 complained of minor pain to the left leg prior to and after the fall. V12 stated V12 reported R1's fall to V2 Director

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S9999	Continued From page 5 of Nursing (DON) and V1 Administrator. V12 was unable to recall if V12 reported R1's fall to anyone else. On 10/23/23 at 10:26 AM V5 Licensed Practical Nurse stated after a fall, the nurses notify the resident's family and physician, and this is documented in a risk management report that carries over into a nursing note in the resident's medical record. On 10/23/23 at 12:04 PM V17 Certified Nursing Assistant stated V17 provided incontinence cares for R1 in bed during night shift on 10/2/23, and R1 complained of pain when R1 was rolled onto R1's side. V17 described R1 as "yelping." V17 stated V17 reported R1's pain to the nurse and that R1 was asking for pain medication. V17 stated it was passed on from the prior shift that R1 had been complaining of pain in R1's hips earlier that night. On 10/23/23 at 3:35 PM V2 Director of Nursing confirmed there is no documentation that R1's physician or representative were notified of R1's fall and left leg pain prior to 10/3/23 when R1 was transferred to the hospital. On 10/24/23 at 9:43 AM V11 Nurse Practitioner stated the nurses notify V11 during the day between 7:00 AM and 7:00 PM, and V11 did not see where V11 was notified of R1's fall or pain on 10/2/23. V11 stated V11 was notified the following morning and gave orders to send R1 to the hospital. V11 stated V11 would have sent R1 to the emergency room right away if V11 was notified of R1's fall and hip pain. V11 was asked what effects would a delay in treating R1's left hip fracture have. V11 stated it would cause R1 pain.	S9999		

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S9999	Continued From page 6 The facility's Accidents & Incidents policy with revised date of March 2021 documents falls will be reported to the resident's physician and the resident's responsible party. The facility's Management of Pain policy revised August 2019 documents: "Pain will be assessed and managed in a timely fashion, especially if it is of recent onset. The physician will be notified of resident's complaint of pain when not relieved by medication as ordered by the physician." The facility's Accidents & Incidents policy with revised date of March 2021 documents falls will be reported to the resident's physician and if necessary, transfer the injured resident to the hospital. This policy documents the resident will be placed on the 24-hour report and follow up charting for 72 hours. Fall risk, neurological assessments, and pain assessments will be completed after each fall. This policy documents not to move the resident after a fall until the resident has been assessed for possible injuries, and each morning the Director of Nursing or designee will review the 24-hour report documentation. The facility's Management of Pain policy revised August 2019 documents: "Pain will be assessed and managed in a timely fashion, especially if it is of recent onset. The physician will be notified of resident's complaint of pain when not relieved by medication as ordered by the physician." The facility's undated Neurological Screenings Guidelines documents neurological assessments should be completed for unwitnessed falls or witnessed falls where the resident hit his/her head and documented on the Neurological Flow Sheet. This guide documents neurological	S9999		

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S9999	Continued From page 7 assessments should be completed every 15 minutes four ties, then every hour four times, then every eight hours nine times, for a minimum of 72 hours. R1's Minimum Data Set (MDS) dated 9/27/23 documents R1 has moderate cognitive impairment, requires extensive assistance of one staff person for transfers, did not receive scheduled pain medication or was offered PRN (as needed) pain medication. This MDS documents R1 did not have any pain during the 5-day lookback period. R1's Care Plan with revised date 10/23/23 documents R1 had a fall with injury, R1 is a new admission, has poor balance, poor communication/comprehension, and unsteady gait. This care plan includes an intervention dated 8/9/23 to "Observe/document /report PRN x 72h (for 27 hours) to MD (Medical Doctor) for s/sx (signs/symptoms): Pain, bruises, change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation." R1's September 2023 Medication Administration Record (MAR) documents R1 received Apixaban (anticoagulant) 5 mg (milligrams) one tablet twice daily from 9/20/23-9/30/23. This MAR documents R1's pain was assessed every shift 9/20/23-9/30/23 with "0" indicating no pain. R1's October 2023 documents R1 does not have routine scheduled or PRN pain medication ordered. This MAR documents R1's pain was assessed each shift on 10/2/23 but does not document a pain score. R1's Nursing Note dated 9/29/2023 at 2:00 PM documents R1 was found at 7:00 AM kneeling on the floor next to R1's bed. R1 was standing on	S9999		

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S9999	Continued From page 8 R1's right leg and kneeling on R1's left leg, and partially resting on R1's bed. R1 was assessed and had no apparent injuries and R1 denied hitting R1's head. This note documents an initial neurological assessment was completed and within normal limits. There is no documented post fall neurological assessments in R1's medical record after the initial assessment. R1's Nursing Note dated 9/30/2023 at 1:56 AM documents R1 denied pain. There are no documented post fall assessments/monitoring in R1's medical record after the initial assessment. There are no documented post fall assessments after the initial assessment following R1's 10/2/23 fall until 10/3/23 at 10:03 AM (almost 19 hours after R1's fall). R1's Nursing Note dated 10/3/23 at 10:03 AM documents R1 complained of left hip pain rated a 10 on a 0-10 scale, and R1 was unable to bear weight related to R1's fall on 10/2/23. This note documents V11 Nurse Practitioner was notified and gave orders to send R1 to the emergency room. There is no documentation that V11 or V4 Physician were notified of R1's fall or left hip pain prior to 10/3/23 at 10:03 AM. R1's Fall Investigation dated 10/3/23 documents on 10/2/23 V12 RN lowered R1 to the ground from the wheelchair and R1 initially complained of left hip pain rated 3 out of 10. The following morning R1 was transferred to the emergency department where x-ray showed left intertrochanteric hip fracture. This investigation documents per V12's interview, V12 and two Certified Nursing Assistants (CNAs) assisted R1 from the floor to standing position and R1 complained of left leg pain. R1 had range of motion as within normal limits. V12 finished the remainder of V12's shift and R1 did not have any	S9999		

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S9999	Continued From page 9 further complaints of left leg pain. This investigation documents per V3 Licensed Practical Nurse (LPN) interview, V3 cared for R1 on the morning of 10/3/23. R1 was in bed when V3 arrived at 6:00 AM and a CNA reported that R1 was working with therapy and yelling out in pain. This interview documents V3 attempted to perform range of motion to R1's left leg, R1 yelled out in pain, and rated the pain as a 10 on a 0-10 scale. V3 asked R1 what happened, and R1 stated R1 fell last night. This investigation documents per V5's (LPN) interview, on 10/3/23 V5 was asked to come to R1's room due to R1 complaining of severe pain and R1 was unable to get out of bed. R1 was sitting on the side of the bed and R1's left upper thigh looked swollen. R1 complained of pain when V3 touched R1's thigh. R1 was laid down and V3 noted distinct difference in length between R1's right and left leg, with the left leg appearing shorter. The investigation concludes that after review of evidence and statements, R1 sustained a fall at the facility with injury identified on 10/3/23. R1's Emergency Department Note dated 10/3/23 documents R1 complained of left upper leg pain following a fall last night. This note documents R1 reported falling out of R1's wheelchair landing on R1's left side and left hip. R1 complained of left hip pain, has not received any pain medication, and was transferred to the hospital. This note describes R1's left hip pain as "maximal". R1's Hospital Admission History & Physical dated 10/3/23 at 12:25 PM documents R1 presented to the emergency room after a fall with left hip pain and "Left Intertrochanteric hip fracture after fall". This physical also notes R1 has a diagnosis of Osteopenia (a disease that weakens bones). R1's Left Femur x-ray dated 10/3/23 at 10:12 AM documents: "History: Pain after fall" and	S9999		

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S9999	Continued From page 10 "Findings: Left intertrochanteric hip fracture with moderate comminution and significant angulation." R1's Orthopedic Surgery Operative Note dated 10/6/23 documents R1 required surgical nailing to repair R1's left hip fracture. On 10/23/23 at 9:40 AM R1 stated R1 had a recent fall while reaching for the remote, R1 slid from R1's wheelchair, and fell to the floor. R1 stated R1 told the staff that R1 had left hip pain and R1 had left hip surgery while at the hospital following R1's fall. R1 was unable to give additional details of the fall on 10/2/23 and did not recall falling on 9/29/23. On 10/23/23 at 1:39 PM R1 was lying in bed and had visible scarring to the left outer thigh, where staples had been removed. R1 had an incision with intact staples to the left hip. On 10/23/23 at 8:40 AM V3 LPN stated V3 was the nurse who sent R1 to the hospital on the morning of 10/3/23. V3 stated R1 was complaining of left leg pain and R1 reported that R1 had fallen the night before. V3 stated nothing was passed on in shift report regarding R1's fall/pain. V3 stated R1 had generalized leg swelling and R1 would not allow V3 to assess range of motion because R1 was in so much pain. On 10/23/23 at 8:47 AM V6 Physical Therapy Assistant stated around 8:00 AM on 10/3/23 R1 was lying in bed and V7 Certified Occupational Therapy Assistant sent a message to V6 saying R1 was screaming every time R1 moved R1's leg. V6 stated R1 told V6 that R1 fell out of R1's wheelchair the night before while trying to reach the remote. At 1:00 PM V6 stated V6 provided R1's therapy session prior to R1's fall on 10/2/23 and R1 had no complaints of pain to the left hip or	S9999		

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S9999	Continued From page 11 signs of injury prior to 10/3/23. On 10/23/23 at 10:05 AM V12 RN stated on 10/2/23 between 3:00 PM and 4:00 PM V12 found R1 sitting on the edge of R1's wheelchair in R1's room, attempting to reach for a remote control. V12 stated V12 tried to scoot R1 back in the wheelchair and was unable, so V12 lowered R1 to the floor onto R1's buttocks with R1's legs extended. V12 stated R1 complained of minor pain to the left leg prior to and after the fall. V12 stated V12 reported R1's fall to V2 Director of Nursing (DON) and V1 Administrator. V12 was unable to recall if V12 reported R1's fall to anyone else. On 10/23/23 at 10:26 AM V5 LPN stated V5 was called to R1's room that morning (10/3/23) due to R1 having trouble sitting up. V5 stated R1 complained of pain to the upper thigh, R1 was laid back down, and had swelling to R1's thigh. V5 stated when R1 laid down there was a difference in length between the right leg and left leg, and R1 told V5 that R1 had fallen the night before. On 10/23/23 at 12:04 PM V17 CNA stated V17 provided incontinence cares for R1 in bed during night shift on 10/2/23 and R1 complained of pain when R1 was rolled onto R1's side. V17 described R1 as "yelping." V17 stated V17 reported R1's pain to the nurse and that R1 was asking for pain medication. V17 stated it was passed on from the prior shift that R1 had been complaining of pain in R1's hips earlier that night. On 10/23/23 at 2:15 PM V16 CNA stated V16 was R1's assigned CNA for 2nd shift on 10/2/23. V16 stated R1 was yelling out in pain that night around 6:00 PM or 7:00 PM and R1 complained of left hip pain. V16 stated V16 required V12's	S9999		

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assistance to transfer R1 to bed, and R1 stood on both legs during the transfer. On 10/23/23 at 2:53 PM V13 CNA stated at the beginning of second shift on 10/2/23 V12 told V13 that R1 had fallen. V13 stated V13 and V12 assisted R1 to a standing position from the floor following R1's fall. V13 confirmed a mechanical lift or gait belt was not used during this transfer. V13 stated R1 did not take any steps and complained of left leg pain and R1 continued to complain of R1's leg hurting the rest of the night.

On 10/23/23 at 1:05 PM V6 Physical Therapy Assistant stated V6 provided R1's therapy session on 10/2/23 and R1 performed exercises and transfers without any complaints or problems that day.

On 10/23/23 at 11:06 AM V2 DON stated when a fall occurs the nurses should complete an initial assessment of pain and injury and notify the Physician/Nurse Practitioner. V2 stated post fall assessments/monitoring for pain/injury should be conducted every shift for 72 hours following the fall and documented in a nursing note. V2 stated the nurses could be better at documenting falls and post fall assessments. At 11:25 AM V2 stated unwitnessed falls should have a neurological assessment form uploaded under the miscellaneous tab in the resident's chart. V2 confirmed there were no post fall neurological assessments completed after R1's fall on 9/29/23. At 3:35 PM V2 stated if a resident falls, they are to be transferred off of the floor with a full mechanical lift. V2 confirmed staff should have used a full mechanical lift to transfer R1 off of the floor on 10/2/23. V2 confirmed the nurses are expected to report resident falls and pain to the physician, R1's post fall assessments were not consistently documented following R1's fall on the

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9/29/23, there are no documented post fall assessments after R1's initial assessment on 10/2/23, and there is no documentation that R1's physician was notified of R1's fall and complaints of left leg pain until 10/3/23.

On 10/24/23 at 9:43 AM V11 Nurse Practitioner stated the nurses notify V11 during the day between 7:00 AM and 7:00 PM and V11 did not see where V11 was notified of R1's fall or pain on 10/2/23. V11 stated V11 was notified the following morning and gave orders to send R1 to the hospital. V11 stated V11 would have sent R1 to the emergency room right away if V11 was notified of R1's fall and hip pain. V11 stated the nurses should monitor range of motion and pain as part of post fall assessments for 72 hours after a fall. V11 stated R1 has diagnoses of Vitamin D deficiency and Bone Density Disorder that increase R1's risk for fractures. V11 stated V11 assumes R1's hip fracture is the result of R1's fall, since the fall occurred the day prior. V11 was asked what effects would a delay in treating R1's left hip fracture have. V11 stated it would cause R1 pain.

2.) R2's Nursing Note dated 9/16/2023 at 9:43 AM documents R2 was standing at the nurses' station and fell. R2's Fall Incident Report dated 9/16/23 at 9:50 AM documents R2's fall was witnessed, R2 did not hit R2's head, and a head-to-toe assessment was conducted. This report documents R2 had an injury to the right rear iliac crest. The only documented post fall assessment in R2's medical record is a nursing note dated 9/17/2023 at 12:57 AM.

R2's Nursing Note dated 9/20/23 at 6:51 PM documents R2 was ambulating in the hall with R2's wheeled walker, tripped over a wet floor

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sign, lost balance, and sat on R2's bottom. This note documents range of motion was within normal limit and R2 had no injury or complaints of pain. The only documented post fall assessment is noted in V11 Nurse Practitioner Progress Note dated 9/21/2023 at 3:26 PM.

R2's Nursing Note dated 10/06/2023 at 10:00 AM documents a loud crash was heard from R2's room and R2 was found lying on the floor with R2's head near R2's dresser. Neurological assessments were initiated, and range of motion was assessed. R2's skin was assessed with no new findings. R2's Nursing Notes document the only post fall assessments were completed on 10/07/2023 at 1:17 PM, 10/07/2023 at 4:52 PM, and 10/8/23 at 1:52 PM.

On 10/23/23 at 11:06 AM V2 DON stated post fall assessments/monitoring for pain/injury should be conducted every shift for 72 hours following the fall and documented in a nursing note. V2 stated the nurses could be better at documenting falls and post fall assessments.

R2's Admission Minimum Data Set (MDS) dated 8/30/23 documents R2 has severe cognitive impairment, R2 requires supervision assistance of one staff person for transfers and locomotion on/off the unit, and R2 requires limited assistance of one staff for toileting. This MDS documents R2 is occasionally incontinent of bladder and frequently incontinent of bowel. R2's Fall Risk Assessment dated 9/5/23 documents R2 is at high risk for falls.

R2's Care Plan revised 9/18/23 documents R2 has hypotension, poor balance, poor communication/comprehension and R2 has had falls. This Care Plan includes interventions for

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S9999	Continued From page 15 R2's family to provide new slippers (dated 10/19/23) and nonskid socks and better fitting slippers (dated 9/21/23). R2's Fall Investigation dated 9/5/23 at 12:06 PM documents R2 was found lying on the floor of R2's room with one shoe on and one shoe off. R2 had a skin tear to the left elbow. The root cause is documented as "resident (R2) self-ambulating" and the intervention is "call don't fall sign". R2's Fall Investigation dated 9/5/23 at 4:32 PM documents R2 was found lying on the floor in R2's doorway of the bathroom with skin tears to the right and left arms that were bleeding. The root cause of this fall is documented as orthostatic hypotension and the intervention was to send to the emergency room for evaluation. R2's Fall Investigation dated 9/16/23 at 9:50 AM documents R2 was standing at the nurse's station and fell. R2 had an injury to the right rear iliac crest (buttock). The documented root cause of the fall was that R2's legs became weak causing R2 to fall, and R2's blood pressure was low for R2. R2 was recently diagnosed with orthostatic hypotension (low blood pressure with position changes) and the intervention was to monitor orthostatic blood pressures for three days. R2's Fall Investigation dated 9/20/23 at 6:51 PM documents R2 was walking with R2's wheeled walker in the hallway, tripped over a wet floor sign causing R2 to lose balance and fall. This note documents under the cause that R2's slippers were not fitting well, and nonskid socks were applied as the immediate intervention. This note documents that R2's poor fitting slippers contributed to R2's fall and better fitting slippers will be purchased. R2's Fall Investigation dated 10/6/23 at 10:00 AM documents there was a loud crash heard from R2's room and R2 was found lying on the floor with R2's head near R2's	S9999		

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S9999	Continued From page 16 dresser. R2 reported that R2 was attempting to sit on the edge of the bed and missed the bed. This investigation documents R2 as a one-person physical assist and the intervention was to offer R2 to lay down after meals. There is no documentation that interviews were conducted as part of R2's fall investigations to determine when R2 was last checked on or toileted prior to each fall, or what R2 was last observed doing prior to each fall. R2's September 2023 Medication Administration Record (MAR) and Vitals Log do not document R2's orthostatic blood pressure readings on 9/22/23 and 9/23/23 as scheduled/ordered and as part of R2's post fall intervention for R2's 9/20/23 fall. R2's Nursing Note dated 10/18/2023 at 2:42 PM documents R2 was found on the floor of R2's room facing roommate's (R4) bed. R2 had on "slip on" slippers. R2 stated R2 hit R2's head. This note documents R2's family was contacted to bring in nonskid slippers with a back/heel coverage. R2 kept pointing to the gauze on the back of R2's hand from a blood draw, and R2 was anxious because of the blood draw. This note documents R2's left hand grasp was greater than R2's right hand, which is baseline for R2. R2's Nursing Note dated 10/18/2023 at 8:10 PM documents x-ray was ordered for right ring finger swelling. R2's Nursing Note dated 10/19/2023 at 10:11 AM documents R2 had right hand swelling with bruising to the right ringer finger, and R2 was unable to perform range of motion which was a change compared to the previous day. R2's Right Hand X-ray dated 10/19/23 at 3:16 PM documents "Impression: Subluxation (partial dislocation) seen at the proximal interphalangeal	S9999		

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joint (middle joint) of the fourth finger posteromedially." R2's Emergency Room Note dated 10/19/23 at 5:19 PM documents R2 presented with finger injury after fall yesterday, per facility RN (Registered Nurse) R2 fell yesterday and tried to reach out to catch R2's self. Staff noted tenderness, swelling, and deformity of right ring finger this morning. This note documents R2's right ring finger interphalangeal dislocation required gentle traction to correct the dislocation and R2's finger was placed in a splint.

On 10/23/23 at 9:14 AM R2's right hand was observed wrapped in an elastic bandage. R2 was walking in R2's room per self with no staff present in R2's room and R2 was wearing slippers with an open back. R2 was asked about R2's right hand, and R2 replied that R2 had a recent fall. R2 was unable to provide any additional details regarding any of R2's falls. On 10/23/23 at 9:14 AM R4 stated R4 witnessed R2's recent fall. R4 stated when R2 fell, R2's finger got "hung up" on the wheelchair. R4's MDS dated 9/27/23 documents R4 is cognitively intact. At 10:25 AM R2 was lying in a bed positioned low to the floor and R2 was wearing open back slip-on slippers.

On 10/23/23 at 10:33 AM V5 Licensed Practical Nurse (LPN) was working when R2 fell about a month ago, R2 was walking in R2's room, lost balance, and fell near R2's dresser causing a skin tear to the elbow. V5 described R2 as very confused, has poor safety awareness, and requires a lot of reorientations. V5 stated R2 requires standby assistance of staff for transfers and walking, and standby means walking side by side with R2. V5 stated R2 walks with a wheeled walker and frequently forgets to use R2's walker.

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On 10/23/23 at 10:36 AM V3 LPN stated R2 had a prior fall when R2 was standing at the nurse's station, got weak, and fell. R2 had R2's walker with R2, and there was no staff walking with R2 at the time. V3 stated R2 had a bruise to R2's back following R2's fall.

On 10/23/23 at 1:28 PM V8 LPN stated (in regard to R2's fall on 10/18/23) R2 was found lying on the floor with R2's bed in low position. V8 stated R2's roommate (R4) witnessed R2's fall and R4 said that R2 attempted to stand from R2's bed and fell. V8 stated R2 was wearing open back slippers and following R2's fall V8 requested R2's family provide different slippers. R2 had blood drawn just prior to R2's fall and was anxious regarding the blood draw. V8 stated R2 assessed R2's hand grasps which the right was weaker than the left, per R2's baseline, and R2's hand grasps remained the same for R2's shift. V8 stated the next morning R2's finger was completely different; it was swollen and very bruised and at that time V8 changed R2's x-ray order to STAT (emergency).

On 10/23/23 at 3:35 PM V2 Director of Nursing (DON) reviewed R2's fall investigations. V2 stated R2's falls on 9/5/23 were unwitnessed and R2 was self-ambulating in R2's room. V2 stated the root cause of R2's fall on 9/5/23 at 4:32 PM was R2's orthostatic hypotension and R2 was transferred to the emergency room as the post fall intervention. V2 stated R2's fall on 9/16/23 was witnessed, R2's legs became weak and R2 fell. V2 stated the post fall intervention was to monitor orthostatic blood pressures for three days, and this should be documented on R2's MAR or vitals log. V2 confirmed R2's MAR and vitals log do not document blood pressure readings on 9/22/23 and 9/23/23. V2 stated R2's

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fall on 9/20/23 was witnessed, the root cause was R2 lost balance and R2's slippers were a contributing factor. V2 stated the facility provided R2 with new slippers with a back, heel coverage. V2 stated R2's fall on 10/6/23 was unwitnessed, the root cause was R2 attempted to sit on the edge of the bed, and the post fall intervention was staff to offer to lay R2 down after meals. V2 stated R2 was found on the floor on 10/18/23, the root cause was R2 was self-ambulating in poor fitting slippers, and the post fall intervention was the facility contacted R2's family to provide new slippers. V2 stated R2's slippers should have been removed from R2's room after R2's fall on 9/20/23. V2 confirmed R2's slippers worn on 10/23/23 and during the 10/18/23 fall were the same slippers that R2 was wearing during R2's fall on 9/20/23. V2 stated R2's dislocated finger was identified on 10/19/23 and was a result of R2's fall on 10/18/23. V2 confirmed R2's fall investigations are not thorough and do not include when R2 was last checked on or toileted prior to each fall or what R2 was doing when last observed by staff.

On 10/24/23 at 9:43 AM V11 Nurse Practitioner was asked the cause of R2's dislocated finger. V11 stated R2 had a fall on 10/18/23, the day prior, and V11 could speculate that the injury was a result of R2's fall. V11 confirmed this type of injury would be consistent with a fall with and the resident's hand positioned in the wheelchair spokes/wheel. V11 stated slippers with a back would have provided better support.

3.) R3's Fall Incident Report dated 9/30/23 at 4:45 PM documents resident had a fall, R3 was laying on the floor near his wheelchair on his left side. R3's Medical Record does not include nursing notes referencing the fall dated 9/30/23 at 4:45

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S9999	Continued From page 20 PM. R3's Incident Report dated 10/12/23 at 7:10 PM documents resident was observed sitting on the floor in front of his wheelchair. R3 stated he forgot to lock the brakes on his wheelchair and slid from his wheelchair while reaching for an object on the floor. R3's incident report dated 10/12/23 at 7:10 PM does not include staff interviews or the last time resident was seen or checked for safety. On 10/23/23 at 9:48 AM R3 stated he slid from his wheelchair to the floor at his bedside while reaching for an object he dropped on the floor. On 10/23/23 at 11:06 AM V2 Director of Nursing stated the nurses could be better about documenting falls. On 10/24/23 at 8:37 AM V2 reviewed R3's nursing notes and confirmed there is no documentation that R3 fell on 9/30/23. On 10/24/23 at 11:00 AM V2 Director of Nursing reviewed R3's nursing notes/incident report and confirmed R3's fall investigation dated 10/12/23 is not thorough and does not contain staff interviews. R3's Incident Report dated 10/12/23 7:10 PM documents R3 fell with no injury noted. R3 was found sitting on R3's bottom in front of R3's wheelchair. After the initial assessment there are no documented post fall assessments in R3's record following this fall until 10/16/2023 at 5:57 AM. R3's Incident Report dated 09/30/23 4:45 PM documents R3 was found lying on the floor of R3's room on R3's left side. R3 had a skin tear to the right hand. After the initial assessment there are no documented post fall assessments in R3's record following this fall.	S9999		

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S9999	Continued From page 21 On 10/24/23 8:37 AM V2 Director of Nursing reviewed R3's nursing notes and confirmed R3 did not have documented post fall assessments every shift following R3's falls. The facility's Accidents & Incidents policy revised March 2021 documents resident incidents/accidents will be investigated and documented on an incident report, the charge nurse is responsible for conducting an immediate investigation of the incident/accident, and appropriate interventions will be implemented. This policy documents the Director of Nursing or designee will investigate incidents/accidents and the interdisciplinary team will be notified of incidents/accidents to make changes on the resident's care plan as needed. This policy documents incidents/accidents will be documented in a nursing note. (A)	S9999		