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
	IL6016935	A. BUILDING: ______ B. WING ______	C 03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT VILLAGE LINCOLN PARK	700 WEST FULLERTON AVENUE CHICAGO, IL 60614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigations: 2381743/IL157015 2381821/IL157104-No Deficiency	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.710a) 330.710b) 330.710c)1)2)3)A)B)C)D)F) 330.780a) 330.780b) 330.780c) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. b) All of the information contained in the policies shall be available for review by the Department, residents, staff and the public. c) The written policies shall include, but are not limited to, the following provisions: 1) Admission, transfer and discharge of residents, including categories of residents accepted and not accepted, residents that will be transferred or discharged, transfers within the facility from one room to another, and other types	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 of transfers. 2) Resident care services including physician services, emergency services, personal care services, activity services, dietary services and social services. 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: A) Analysis of the risk of injury to residents and nurses and other health care workers, taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs. B) Education of nurses in the identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling. C) Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment. D) Restriction, to the extent feasible with existing equipment and aids, of manual resident handling or movement of all or most of a resident's weight, except for emergency, life-threatening, or otherwise exceptional circumstances. F) Development of strategies to control risk of injury to residents and nurses and other health	S9999		

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S9999	Continued From page 2 care workers associated with the lifting, transferring, repositioning, or movement of a resident. Section 330.780 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. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 330.785, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.	S9999		

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These requirements were NOT MET as evidenced by:

Based upon observation, interview and record review the facility failed to follow policies and procedures, failed to ensure that all direct care staff receive fall prevention training, failed to ensure that staff are aware of resident fall prevention interventions, failed to ensure that residents are transferred safely, failed to document residents injuries (R4, R6) in progress notes, failed to notify IDPH (Illinois Department of Public Health) of serious injuries within regulatory requirements for one of five residents (R5) reviewed for falls, failed to assess (R1, R3, R5) for fall risk, failed to revise (R1, R3, R4, R5, R6) care plan post fall, failed to determine root cause of (R3, R4, R6) falls, and failed to implement appropriate fall prevention interventions for four of five residents (R1, R3, R4, R6) review for falls. These failures resulted in R1's (1/10/23) fall resulting in pelvic fracture. R5's (1/31/23) fall resulting in L2 (lumbar) fracture. R4's (11/18/22) fall resulting in laceration requiring repair. R4's (2/6/23) fall resulting in left hip fracture. R6's (2/24/23) fall resulting in right pelvic fracture.

Findings include:

On (2/28/23) IDPH (Illinois Department of Public Health) received allegations regarding multiple falls resulting in serious injuries, and lack of staff training for resident transfers & fall protocols.

R1's diagnoses include dementia, Parkinson's, gait abnormality, muscle wasting and atrophy.

R1's (January 2023) care plan states resident has contracted right and left hands. Resident has

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50% weight bearing to right lower extremity. Transfer assistance by two staff members. R1's fall risk assessment is blank. R1's MOCA (Montreal Cognitive Assessment) Test Score is blank. The MOCA assesses multiple cognitive domains including attention, concentration, executive functions, memory, language, visuospatial skills, abstraction, calculation and orientation.

R1's progress notes include (1/10/23) found resident on floor. Resident stated she fell out of bed hitting her head. Resident couldn't move.

R1's progress note dated (1/11/23) resident returned to facility (from hospital) with pelvic fracture. On 3/7/23 at approximately 2:31pm, surveyor inquired about R1's (1/10/23) fall V21 (Memory Program Coordinator) stated "She (R1) was in bed, reaching for a pillow that fell on the floor and she fell over on the floor."

R1's (1/10/23) fall investigation states resident's gait and balance is poor.

R1's (undated) fall interventions state PAL's (Personal Assistant Liaisons) were re-educated to always lower the bed before leaving the room. Resident re-educated to always call for assistance and using the call light [R1 has dementia]. Neither of which are on R1's care plan.

On 3/1/23 at 11:22am, surveyor inquired about R1's fall prevention interventions. V4 (PAL) stated "She's got the floor mat (referring to a small, thin electronic mat on the floor) and the recording (referring to video monitor in the room). The alarm (referring to the electronic mat) lets us know if she stands on it." [The electronic floor mat

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S9999	Continued From page 5 alerts staff that the resident is getting out of bed however does not prevent injuries from falling]. Surveyor requested that R1's bed be lowered V4 lowered the bed completely however it was not low to the ground. R1 was observed seated in a wheelchair (atop of a mechanical lift sling) surveyor inquired who assisted R1 to the wheelchair today R1 stated "(V4's name)." Surveyor inquired if additional staff assisted R1 to the wheelchair R1 responded "No." Surveyor inquired if V4 transferred R1 to the wheelchair today by herself V4 replied "I did." Surveyor inquired how R1 was transferred V4 stated "She (R1) hugs me, I (V4) take her by the pants and pivot her (R1) to the wheelchair" [R1 has 50% weight bearing to right leg and requires transfer assistance by two staff]. Surveyor inquired if a gait belt was in use during R1's transfer V4 responded "No." Surveyor inquired about the purpose of using a gait belt V4 replied "To make sure that she (R1) doesn't fall." A mechanical lift was observed in R1's room. Surveyor inquired about the requirements for transferring residents. V4 stated, "For the (mechanical lifts) there's supposed to be two people." Surveyor inquired if two staff are currently available to transfer residents on the unit. V4 responded, "No, there's supposed to be four PAL's today and unfortunately there's only three right now." Surveyor inquired if V4 received fall prevention training. V4 replied, "Yes, when I started, I'm due for another one soon." V4 affirmed she's been employed by the facility "one year and eight months." On 3/2/23 at 1:32pm, surveyor inquired about R1's cognitive/functional status V8 (RN/Registered Nurse) stated she is oriented maybe times two and in a wheelchair. Surveyor inquired about R1's fall prevention interventions	S9999		

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V8 responded I know that her bed is in the low position [R1's bed is not low, in the lowest position] and there's one of those pads under the bed. I guess if she (R1) was to come out of bed it would alarm, that's not going to prevent her (R1) from getting hurt or anything [referring to the electronic mat]."

R1's fall risk assessments were requested on 3/1/23 and 3/2/23 however not received during this survey.

R5's diagnoses include dementia and vertigo.

R5's (January 2023) care plan states resident demonstrates difficult or challenging behaviors requiring constant redirection. R5's care plan states hands on assistance with dressing because unable to stand safely during tasks. R5's fall risk assessment is blank. R5's MOCA (Montreal Cognitive Assessment) Test Score is blank.

R5's (1/31/23) progress notes state writer alerted by PAL that resident was on the floor. Per PAL, resident tried to throw chair at her and fell to the floor. Resident landed on left hip and buttocks. Upon assessment, resident complained of pain to left hip and buttocks. Sent to ER (Emergency Room) for further evaluation. Writer placed call to hospital, resident has been diagnosed with a L2 fracture. On 3/7/23 at approximately 2:31pm, surveyor inquired about R5's (1/31/23) fall. V21 stated "I think she woke up around 2 in the morning and was pounding on resident's door. The caregiver brought her back to her room and she started slamming and yelling after they did that. The caregiver tried to distract her with coloring and puzzles. She kept getting agitated and went to pick up a chair out of frustration, lost

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her balance and fell."

R5's (2/2/23) fall investigation states resident's balance and gait is poor using walker.

R5's (undated) fall interventions state, instructed caregivers to leave alone when aggravated. Family to increase visitation. Frequent wellness checks. [None of which are on R5's care plan].

On 3/1/23 at 11:32am, R5 was observed seated in a wheelchair participating in an activity with V3 (Enrichment Leader) present. Surveyor inquired about R5's fall prevention interventions. V3 stated, "We make sure her brakes are locked on the wheelchair and keep an eye on her" [Leave alone when aggravated was not inclusive]. Surveyor requested R5's name. R5 responded, "I don't care." Surveyor inquired if R5 recently fell. R5 nodded her head no and replied "Nothing." Surveyor requested the current year R5 did not respond. At 11:43am, R5's bed was not in the low position. Surveyor inquired if R5's bed was in low position V3 located a remote control however was unable to lower R5's bed. Surveyor inquired about the height of R5's bed. V3 stated, "I know on some people they don't have the legs on the bed or it's lower to the floor."

R5's fall risk assessments were requested on 3/1/23 and 3/2/23 however not received during this survey.

R4's diagnoses include dementia and bilateral hearing loss.

R4's (11/9) fall risk assessment determined a score of 10 (high risk).

The fall log affirms R4 fell on the following dates:

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S9999	Continued From page 8 8/18/22, 9/12/22, 11/14/22, 11/18/22, 12/11/22, 1/20/23, 1/25/23, 2/6/23 (twice) therefore nine (9) times in the past 6 months. On 11/18/22, R4 returned to facility with stitches. On 2/6/23, R4 was admitted for left leg fracture. R4's (December 2022) care plan states hands on assistance with dressing because unable to stand safely during tasks. Physical functioning: no assistance. Ambulates independently [revisions are excluded]. R4's MOCA test score is blank. R4's (11/18/22) progress note states resident found sitting on the floor with laceration to the back of head. R4's (11/18/23) initial/final incident report states resident rolled out bed and hit her back against the bed side table and fell. She sustained laceration to the head. R4 was transported to hospital for evaluation. Resident returned to facility with two staples placed to scalp. R4's (11/18/22) fall investigation excludes root cause analysis of the fall. [All the selections are marked No]. R4's (undated) fall interventions include educate resident on safety measures. Clear clutter and trip hazards. Encourage resident to ask for assistance. Anticipate needs before leaving the room. Frequent round on the resident. Engage resident in activities on the floor. Move the bed night table away from the bed. [None of which are on R4's care plan]. R4's (2/6/23) initial/final incident report states resident tripped over on her feet and fell while walking in the hallway. She rolled over and hit the back of her head on the floor. Resident unable to	S9999		

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bear weight on left leg. Transferred resident to the hospital. Resident admitted for left hip fracture.

R4's (2/6/23) fall investigation excludes a root cause analysis of the fall [All the selections are marked No].

On 3/1/23 at 11:49am, surveyor inquired about the current (3rd floor) staffing. V5 (PAL) stated, "We have 3 PAL's on the floor, usually it's four. The Nurse comes down every hour." Surveyor inquired about R4's fall prevention interventions. V5 responded, "I'm sure she had her mat in the room and she has a walker." Surveyor inquired about R4's cognitive status. V5 replied, "She kind of like has word salad, scrambled words but she can show you what she needs." Surveyor inquired if R4 recently fell. V5 stated, "That's what I heard, I wasn't here on that shift. They just said that she tripped and fell with her shoes. I believe she's not in the building, she's at rehab." At 11:52am, surveyor inspected R4's bed which appeared elevated due to use of box spring.

On 3/2/23 at 1:44pm, surveyor inquired about R4's fall prevention interventions V8 (RN) stated "She didn't have a walker just walked by herself. Surveyor inquired about the (2/6/23) incident. V8 responded, "I was the Nurse that they called. When she tried to lift her leg, she couldn't so I sent her out 911. Her hip was fractured. The PAL said she just kind of turned and fell. She was kind of confused. She was ambulatory, I guess just walking down the hall."

R6's diagnoses include Alzheimer's disease.

R6's (12/13/22) fall risk assessment determined a score of 11 (high risk).

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S9999	Continued From page 10 The fall log affirms R6 fell on the following dates: 4/4/22, 6/30/22, 9/11/22, 9/28/22, 10/23/22, 10/25/22, 10/26/22, 11/6/22, 11/10/22, and 12/29/22 (twice). [R6's 2/24/23 fall is excluded]. R6's (December 2022) care plan states staff provide additional interventions because resident is a high fall risk. Resident's bed mattress placed on the floor for easy access. Caregiver assigned to be with the resident at night and resident has a private caregiver during the day. Escort assistance while walking to meals and activities. MOCA Test Score: 13 (moderate impairment). R6's (2/24/23) progress note states fall camera detected a fall. Resident ambulating and fell on the floor. Upon assessment resident complained of pain on left hip. The (2/24/23) initial/final incident report states (R6) had a fall while ambulating in her apartment. Resident complained of pain to right hip and leg. Resident transported to hospital. Resident returned to community with right pelvic fracture. R6's (2/24/23) fall investigation excludes a root cause analysis of the fall [All the selections are marked No]. R6's (undated) fall interventions include resident moved to studio apartment. Bed moved against the wall. Caregiver assigned to be with resident at night. Family providing private caregiver during the day. Medication adjusted by medical doctor. [None of which are on R6's care plan]. On 3/1/23 at 11:55am, surveyor inspected R6's room with V3 (Enrichment Leader). R6's bed was not against the wall (as stated in the fall	S9999		

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S9999	Continued From page 11 interventions). Surveyor inquired about R6's fall prevention interventions. V3 stated, "She does have a low bed. She can walk, she uses a walker. She has a care giver during the daytime" [escort assistance while walking was excluded]. At 11:58am, surveyor inquired if R6 recently fell at the facility. V7 (Caregiver) stated, "Last Friday (2/24/23) I think she was roll off the bed early in the morning. She has like a little crack in the pelvis." Surveyor inquired if R6 is oriented. V7 responded, "She kind of like a little bit. She knows who her husband is but sometimes she makes a little mistake." At 12:02pm, surveyor inquired about the (2/24/23) fall R6 was aphasic and stated "I was in the room. I had a piece that slipped so I was very hard on the floor. Right away they came to pick me up." Surveyor inquired how many staff are required for R6's transfers from the bed to the wheelchair. R6 responded, "1 or two it depends on who can up here." Surveyor inquired how staff transferred R6 to the wheelchair today. R6 stated, "Like this" and touched surveyor's shoulders. Surveyor inquired if staff transfer R6 by lifting her under the arms R6 nodded her head yes. On 3/2/23 at 1:51pm, surveyor inquired about R6's cognitive/functional status. V8 (RN) stated, "I would say she's alert and oriented times 1-2 with some confusion. Surveyor inquired about R6's fall prevention interventions "I really don't know what her fall prevention plan is, I know she has a sitter. I've never seen on someone, a written plan on what we're going to do after a fall here (at facility). I've never seen (staff) use a gait belt here. Surveyor inquired about facility staffing. V8 replied, "They're always short here." On 3/8/23 at 10:50am, surveyor inquired about R6's (2/24/23) fall. V13 (Licensed Practical	S9999		

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Nurse) stated, "We had a fall camera in the room, and it alerted us. When I checked it, she had got up from the bed went to the garbage she removed her pull up and throw it in the garbage. She was going to turn, and she fell. When I assessed her, she complained of pain in her hip and her leg, and I call 911." Surveyor inquired about requirements for falls. V13 responded, "You're supposed to document what happened and the complaint of the patient, our intervention and we fill out an incident report, and fall prevention checklist and assess why they fell."

R3's diagnoses include dementia.

The fall log affirms R3 fell on the following dates: 1/4/23, 1/10/23, 1/16/23, 1/17/23, 1/18/23, 1/20/23, 1/22/23 (twice), 1/30/23, 2/2/23, 2/4/23, 2/8/23, 2/10/23, 2/11/23. R3's progress notes affirm that he also fell on 2/28/23. [15 falls within two months].

R3's (12/13/22) MOCA determined a score of 1 (severe impairment).

R3's (January 2023) care plan states provides assistance because unable to stand safely during tasks. Escort assistance while walking to meals and activities. Staff provides occasional reminders, cueing and routine wellness checks. R3's fall risk assessment is blank.

R3's (2/4/23) progress notes state resident slipped on the floor while attempting to get back in bed. No injuries noted. Resident has had 3 incidents of being found on the floor over the last 3 days. [The fall log excludes R3's 2/3/23 fall].

On 3/1/23 at 12:15pm, surveyor inquired about R3's fall prevention interventions. V6 (PAL)

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stated, "He had these bed railings (observed on the floor), but they weren't good, so the son got these ones (referring to bed rails in an unopened box). Even with these (bed rails) he was still able to get out the bed and fell." Surveyor inquired how R3 was transferred from the bed to wheelchair today. V6 responded, "What I do is, I swing his legs and put my right leg between his legs hold him up and turn him to the wheelchair." Surveyor inquired is V6 received training for fall prevention or transfers. V6 replied, "I haven't had training since I started, just when I started, I haven't had one for a while. I been here one year four months." Surveyor inquired if gait belts are used for transferring residents. V6 stated, "No, we just got people that use the (mechanical lifts) to hold them to transfer from the bed to the chair." Surveyor inquired if a gait belt was provided by the facility for staff use. V6 responded, "No." Surveyor inquired why R3 does not have a low bed. V6 replied, "We was trying to tell the son that he would do better with the hospital bed, but he keeps refusing." Surveyor inquired if R3 is able to walk. V6 stated, "At first he was walking but now he's just in the wheelchair." At 12:19pm, surveyor inquired if R3 recently fell. R3 stated, "I'm not familiar you see but uh." Surveyor inquired who assisted R3 to the wheelchair today. R3 responded, "My friend." Surveyor inquired what year it is. R3 replied, "Today is, I was here, I was here about seven months ago. I'm not old enough over here."

On 3/2/23 at 1:40pm, surveyor inquired about R3's cognitive/functional status. V8 (RN) stated, "I know he's had a lot of falls. I would say he's alert and oriented times 1-2. When he first came, he was walking but even when he had the walker his gait was unsteady, and he would kind of scoot with the walker. His thing is when he's in the bed

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he would get up by himself. I don't know if it's a language barrier, but he doesn't use the call light." Surveyor inquired about R3's fall prevention interventions. V8 responded, "I'm not sure, I don't know what they put in place for him." Surveyor inquired if the facility provided V8 a list of residents at risk for falls and/or interventions for residents at risk for falls. V8 replied, "No, we don't have anything like that." Surveyor inquired if it was appropriate for R3 to reside in the (sheltered care) facility. V8 stated "No."

Surveyor requested R3's (2/4/23) incident report/investigation and fall risk assessment on 3/1/23, 3/2/23, 3/6/23 and 3/7/23 however the requested documentation was not received. On 3/7/23 at 10:00am, V1 (Executive Director) stated "We can't find the fall assessments and risk assessments on him (R3) for that fall (referring to 2/4/23 incident)." At 10:08am, V2 (Director of Resident Care Services) stated "I was told that everything that we have on him (R3) has been given to you except for this fall intervention (referring to a fall investigation checklist form) which we do not have. The thing was that because it was just a regular fall, we already incorporated interventions on the other fall" and affirmed R3's (2/4/23) fall investigation was not conducted and fall prevention interventions were not revised post fall.

On 3/7/23 at 11:57am, surveyor inquired about staff training for fall prevention and transferring residents safely. V2 stated, "That is part of our orientation, we train as to whatever for that month what we got from the head office and the subject varies. We train based on every month for the particular subject for the month." Surveyor inquired if fall investigations should include root cause analysis. V2 responded, "I'm not aware of

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root cause analysis here, in the hospital yes. But for a shelter care I cannot recall a root cause analysis. Root cause analysis would come along with a risk management we don't have risk management here." Surveyor inquired if residents sustaining multiple falls resulting in serious injuries are appropriate to reside in a sheltered care facility. V2 replied, "To be honest with you no."

On 3/7/23 at 2:31pm, surveyor inquired about training provided to staff working on the memory care units. V21 (Memory Program Coordinator) stated, "We do the lift training and the back safety training just the proper techniques with bending lifting, sitting in a chair correctly those safety protocols. The care givers go through the four days of iPad training it's a wide variety of protocols for (facility name)." Surveyor inquired if fall prevention was included. V21 responded, "I don't remember if it is or not." Surveyor inquired how resident specific fall prevention interventions and resident transfer requirements are communicated to staff. V21 responded, "If a resident requires physical therapy, they (Physical Therapist) will evaluate them to see what that transfer looks like if it's a one-person transfer or (mechanical lift). They (V25/Physical Therapist) communicate with me and V2, we go over items like that with them (staff) it's verbal. She (V25) also sends an email." Surveyor inquired if residents with multiple falls are appropriate for residing in a sheltered care facility. V21 replied, "It's tough for just me to say it's really a collaborative decision to be made with me V1, V2 and corporate. That may be a topic we discuss at the weekly meeting with our management team. I have not had a conversation about them living here, more so the conversation was about implementing fall prevention. It's also looking at

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S9999	Continued From page 16 the interventions that we have in place and is it working." The fall reduction preventative policy (reviewed 1/18/23) states training related to fall management will be completed by (facility name) Nursing and PAL staff during orientation and annually thereafter. The (6/1/22) transferring/lift in-service includes 138 staff however only 29 signatures are inclusive. [Several Nurse's and PAL's signatures are excluded]. The fall prevention completion report excludes V5 (PAL/Personal Assistant Liaison) and V6 (PAL). V4's (PAL) completion date is 6/16/21 (18 months ago). V2 (Director of Resident Care Services) and V23 (Licensed Practical Nurse) are marked "Past Due" on the report. The fall reduction preventative policy (reviewed 1/18/23) states training related to fall management will be completed by (facility name) Nursing and PAL staff during orientation and annually thereafter. All residents will be assessed for risk of falls just prior to, or at the time of, move-in; at re-assessment; or as required by state regulations. A resident care plan with individualized "approach" instructions will be developed by a nurse at each assessment. Instructions and individualized interventions to help mitigate the risk of injury from falls will be included for those residents at risk. The care plan will be updated with each assessment to include updated fall management interventions, as appropriate. Once risks are identified, the resident care plan and approach chart should contain individualized strategies and interventions to minimize the risk of falls and mitigate injury as	S9999		

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S9999	Continued From page 17 much as possible. PALS will be informed of the new interventions. The admission, discharge, and transfer policy (reviewed 1/2012) states; it is the policy of (facility name) to assess all potential residents for their service needs and determine their eligibility for residency at a (facility name) Community. Residents will be re-assessed in the Community if there is a significant change in condition and every 6 months. Only residents who meet the admission and care criteria for Sheltered Care facilities, as set forth in 77 IL Administrative Code Section 330 (the "Regulations"), will be eligible for admission. Residents eligible for admission must be appropriate for, the care and services offered at (Facility name), including assistance with daily living and/or the memory care programs and services offered at the Community. If a resident's needs can no longer be met, the DRCS (Director of Resident Care Services)/ED (Executive Director) will communicate this information with the responsible party and physician. Working with the responsible party and the physician a plan will be immediately developed to transfer the resident to an appropriate facility. R4's (2/6/23) progress notes state writer called to 3rd floor common area for a code yellow. Resident lying on her left side with a pillow under her head. Resident is unable to inform writer how the incident occurred. Resident noted with a large-raised area on the back of her head. Resident complained of pain to left hip. Resident is unable to move left extremity. 911 called. Per PAL (Personal Assistant Liaison), resident was ambulating down the hall when she tripped and fell down in front of common area landing on her left side and hitting the back of her head on the floor.	S9999		

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S9999	Continued From page 18 R4's (2/6/23) initial/final incident report states resident admitted for left hip fracture. R4's progress notes exclude (2/6/23) hip fracture. R6's (2/24/23) progress note states fall camera detected a fall. Resident ambulating and fell on the floor. Upon assessment resident complained of pain in left hip. 911 called. Transferred to hospital. R6's (2/24/23) initial/final incident report states resident returned to community with right pelvic fracture. R6's progress notes exclude (2/24/23) pelvic fracture. On 3/8/23 at 10:50am, surveyor inquired about staff requirements for resident falls V13 (Licensed Practical Nurse) stated "You're supposed to document what happened and the complaint of the patient." R5's (1/31/23) progress notes state (2am) writer alerted by PAL that resident was on the floor. Upon assessment, resident complained of pain to left hip and buttocks. 911 called and sent to ER (Emergency Room) for further evaluation. (12:15pm) Writer placed call to hospital, resident has been diagnosed with L2 fracture. R5's (1/31/23) initial/follow-up incident report states resident was admitted for minor lumbar fracture. IDPH was notified (2/2/23) at 10:39am via smartsheet (two days later). R5's progress notes affirm that the facility was aware of R5's fracture on 1/31/23.	S9999		

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S9999	Continued From page 19 On 3/2/23 at 2:35pm, surveyor inquired about the regulatory requirements for reportable incidents. V1 (Executive Director) responded, "If it's a reportable we should notify IDPH, if there was something with a staff member we would terminate or whatever pending the investigation. You should be notified within 24 hours." On 3/7/23 at 11:57am, surveyor inquired about the regulatory requirement for reportable incidents. V2 (Director of Resident Care Services) stated, "We report those to the State within 24 hours." The reportable incidents and accident policy (reviewed 07/09) states (facility name) will notify the Department of any serious incident or accident, meaning any incident or accident that causes physical harm or injury to a resident. Notification will be made by fax or phone call to the Regional Office within 24 hours of each reportable incident or accident that causes physical harm or injury to a resident. A descriptive summary of each incident or accident will be recorded in the files of each resident involved. (A)	S9999		