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S 000	Initial Comments Complaint Investigation #2325256/IL161343	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210b)4)5) 300.1210d)1) 300.1210d)3) 300.3210t) 300.3240a) 300.3240b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with	S9999		

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each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

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

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resident's medical record.

Section 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act)

These requirments are not met as evidenced by:

A. Based on record review and interview, the facility failed to ensure the licensed nurse provided care and services to the 32 residents residing on the 3rd floor, when V4 (Licensed Practical Nurse) was found sleeping during her shift from approximately 9:15 pm on 6/09/23 to 5:00 am on 6/10/23. V5 and V10 (Certified Nursing Assistants) observed V4 sleeping throughout the night and were unable to wake her. V5 and V10 failed to report to Administrative Staff that V4 had been sleeping, until 4:40 am on 6/10/23, despite having a resident (R3) actively dying on Hospice, a resident (R2) requesting pain medication and another resident (R1) on Hospice that was experiencing a decline in her health. V4 failed to administer R1's nighttime dose of insulin and staff failed to monitor and assess R1 every

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two hours during the night. This resulted in V12 (R1's Family) finding R1 at 5:45 am on 6/10/23, with her head hanging over the side of the bed, verbally non-responsive and experiencing a hyperglycemic episode. Video surveillance confirms that staff did not go into R1's room between 9:09 pm on 6/09/23, when V4 obtained R1's blood glucose level, and 5:45 am on 6/10/23.

B. Based on record review and interview, the facility failed to ensure resident care was delivered in a manner that met the resident's physical and emotional needs after experiencing a decline in health and follow the comprehensive individualized care plan when delivering care, for two of three residents (R1, R3) reviewed for nursing care, in a sample of 32. This failure resulted in R3 experiencing physical distress during the end stages of life.

The facility Abuse and Neglect Policy (revised May 2022), documents "Policy: It is the policy of Sunset Home to provide each resident with an environment free from abuse, neglect, corporal punishment, involuntary seclusion, misappropriation of resident property, exploitation and physical or chemical restraint not required to treat the resident's symptoms, as defined below. Sunset Home shall follow the procedure for reporting and investigation of alleged resident abuse and neglect as outlined below, and in accordance with Skilled Nursing and Intermediate Care Facilities Code (77 Ill. Adm. Code 300.3240). Purpose and Scope: The purpose and scope of this policy and procedure is to inform all individuals of the proper protocol for preventing, reporting and investigating allegations of abuse and neglect as specified in the corporate policy above." The facility policy documents,

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"'Neglect refers to the failure to provide goods and/or services necessary to avoid physical harm, mental anguish, or mental illness."

The Staff Nurse Job Description (Revised 4/16/2020) documents, "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 the current Federal, State, and local standards, guidelines and regulations that govern our facilities, and as may be required by the Director of Nursing or Charge Nurse to ensure that the highest degree of quality care is maintained at all times." The Job Description includes, under "Major Duties and Responsibilities: Direct the day to day function of the nursing assistants in accordance with current rules, regulations and guidelines that govern the long-term care facility. Ensure that the nursing procedures manual is followed rendering nursing care." The policy advises that the licenses nurse is to, "Chart nurses' notes in an informative and descriptive manner that reflects the care provided to the resident, as well as the residents' response to the care. Give/receive the nursing report upon beginning and ending shift duty hours. Provide leadership to nursing personnel assigned to your unit/shift." Under "Nursing Care Functions," it documents that the Staff Nurse is to "Make periodic checks to assure that prescribed treatments are being properly administered by nursing assistants and to evaluate the resident's physical and emotional status. Administer professional services such as: catheterization, tube feeding, suction, applying and changing dressings/bandages, packs, colostomy care, range of motion exercises, care of the dead/dying, etc., as required, within the Nurse

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Practice Act for the State of Illinois. Provide and/or assist other staff with nursing care including performing the duties listed in the Certified Nursing Assistant job description as necessary. Monitor seriously ill residents."

The facility policy titled "Quality of Life (no date)", documents "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Policy Interpretation and Implementation: 1. Residents shall be treated with dignity and respect at all times. 2. 'Treated with dignity' means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth." The policy also documents, "9. Staff shall speak respectfully to residents at all times" and "13. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: Promptly responding to the resident's request for toileting assistance."

On 7/05/23 at 4:47 pm, V2 (Director of Nursing) provided a Resident Bedsheet to reflect the midnight census on 6/09/23, which was 32 residents (R1-R32).

A Resident Bed Sheet, dated 6/09/23, was provided by V2 (Director of Nursing) on 7/05/23 at 4:47 pm. V2 confirmed that was the accurate midnight census of 6/09/23 and it identifies 32 residents

1. R1's electronic medical record documents R1 was admitted to the facility on 5/26/21 and has the current diagnoses of Chronic Pain, Type II Diabetes Mellitus with Hyperglycemia, History of Diabetic Ketoacidosis, Acute Ischemic Heart Disease, Muscle Weakness, Muscle Wasting and

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Atrophy, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease and was placed on Hospice on 6/07/2023. R1's current Plan of Care documents R1 has chronic back pain with instructions for staff to monitor for signs/symptoms of pain and administer Percocet (Narcotic) four times a day. R1's current Plan of Care also documents, "I am high risk for falls (related to) gait/balance problems" and instructs staff to provide "a working and reachable call light, the bed in low position at night; personal items within reach," and "Be sure my call light is within reach and encourage me to use it for assistance when needed." A Minimum Data Set assessment dated 4/12/23 documents R1 had a BIMS (Brief Interview of Mental Status) of 14, which indicates no cognitive impairment. However, Hospice Admission documentation, dated 6/08/23, indicates R1 was placed on Hospice Services due to a physical decline related to malnutrition and cites R1 has experienced increased confusion over the last six months. R1's Hospice Plan of Care, dated 6/08/23, documents under "Mobility/Safety" that R1/Caregivers will "demonstrate safe, effective use of equipment. Interventions: Instruct Patient/Caregiver on fall prevention and safety precautions. (R1) requires assistance of two for transfer but has not been out of bed for 2 days prior to Hospice enrollment. Patient is (a) fall risk. Education to keep bed in low position and call light within reach." R1's Nursing Progress Notes document no Nursing Assessments/Notes from 6/07/23 through 6/09/23 by the facility's licensed nursing staff. The next documented Nursing Note is on 6/10/23 at 6:15 am and reads "(R1) is not opening eyes or responding to staff at this time. Upon checking the blood sugar, it is reading high. (V14/Medical Director) called and order received to give 20 (Units) Humalog now.

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After this, blood sugar came down 495, hospice called again. At this time the hospice nurse informed me she has heard from the daughters, and they are planning on taking (R1) out of here (as soon as possible) today.
Discharge paperwork gathered, medications gathered, and (medical supply company) will be delivering her bed at noon today, ambulance to be scheduled once bed is delivered." Nursing documentation indicates R1 left the facility on 6/10/23 at 12:43 pm with her family in the care of Hospice services.

On 6/26/23 at 3:04 pm, V12 (Family/Healthcare Power of Attorney) stated that R1 has a video camera in her room that is triggered to record with motion or movement. According to V12, on 6/10/12 at 5:25 am, she could "see Mom (R1) dangling over the side of the bed. I tried calling there (facility) to notify the staff and no one answered, it rang and rang. I only live 10 minutes away, so I just drove over there. When I got to Mom's floor, it was a ghost town. There were no staff to be seen. I went into her room, and she was still hanging over the side of the bed and her call light was on the floor. So, I went running down the hall looking for someone to help. The Aides came into her room and set her upright. Mom is not waking up and is lethargic. The Aides left and I tried to get (R1) to drink some water. Around 6:00 am, I started thinking that maybe (R1's) blood sugar was off, she's a Diabetic, so I went to find a nurse. The nurse tried to get a reading of her blood sugar, but it just registered high. The nurse called the doctor, and she got some fast acting insulin in (R1), but she still wasn't responsive. The nurse said they could send to (R1) the hospital, but she would have to come off of Hospice if they did. I looked at the video footage and saw that no one had been in

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(R1's) room since 9:09 pm (6/09/23). The nurse came in then to check her blood sugar and I can see Mom's call light on the floor then. The nurse says (R1's) blood sugar is over 200 and she needs insulin. The nurse never came back in (R1's) room. I could see at 1:13 am (on 6/10/23), Mom raises the head of her bed up with the button on the bed rail and her call light is still on the floor. I couldn't tell what (R1) was trying to do then. Nobody comes in her room at all after 9:09 pm (6/09/23). I was so upset, I just had them discharge her to my house on Hospice. This was not something we planned, but I could not leave her there. Mom died two days later. I heard the nurse working was escorted out of the building for not checking on residents that night." On 7/05/23 at 7:40 am, V12 stated, "Not sure how you put a price on time with a loved one, but I sure wish there was a way to quantify that, as we should have had more time with our mom (R1). I personally moved to Quincy on April 1st to spend more time with her, though I got an amazing 2 months with her, I definitely thought I would have more, we all did."

Video surveillance from R1's room on 5/10/23 at 7:13 pm recorded the following: V17 (Licensed Practical Nurse) enters R1's room, responding to R1's call light being on. R1 is sitting in her recliner. V17 states to R1, "Your call light was on. What do you need?" R1 states something inaudible. V17 then states, "No, that's not your medicine. What do you need? I came to answer your call light. What do you need?" R1 replies, "I need to go to the bathroom." V17 stated, "Well, I'll have someone come and take you in a little bit, OK?" V17 leaves the room before R1 responds. Thirteen minutes later, at 7:26 pm, V17 enters R1's room, accompanied by V18 (Certified Nursing Assistant). V17 states to R1, "OK. (R1)

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you know how to go to the bathroom. I have this aide that's gonna help you to the bathroom. (R1 remains sitting in recliner and says nothing) Please let her help you. Stand up. You know how to stand up. Put your hands on this and stand up. (R1 has the wheeled walker in front of her but is struggling to stand independently. Neither V17 or V18 have a gait belt or are assisting R1 to stand) Show her how you can do it. On the count of three, STAND UP. (R1 can be seen still struggling to stand up independently and is unsure of where to put her hands to help herself stand. R1 is not verbalizing anything and appears confused.) You gotta help yourself, OK? You stand up for those therapists, you can stand up for us. You know how to do it. Push up on the chair and stand up. (R1 continues to struggle with no assistance from V17 or V18) Do you need to go to the bathroom now? Or do you want to wait? (No response from R1 who is sitting and still appears confused) I'm not gonna force you to do this. Do you need help to go to the bathroom? (V17 does not wait for R1 to respond) Do you need to go to the bathroom?" R1 quietly states, "no." V17 then states, "YOU DON'T? Alright. You don't need to go to the bathroom, obviously. Alright (inaudible). Now if you have to go, I have this aide to help you to go to the bathroom. When you need to go, press your call light and we'll come help you. I have to say, you told me you needed to go to the bathroom. I said I was gonna go set some help. She was going to help you. Did you change your mind." R1 responds something that is too quiet to be heard and V17 and V18 leave the room without assisting R1 to the toilet.

Video surveillance from R1's room on 5/11/23 at 8:42 pm recorded the following: V17 enters R1's room as R1 is sitting in her recliner. V17 states,

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"Yes, what do you need (R1)?" R1 replies, "I need to go to the bathroom." V17 states, "(R1) you're gonna have to wait for a little bit. I'm sorry. (V17 then turns off R1's call light) I'm the only person on the floor at the moment. I got a few more people to do and I'll help you to the bathroom." V17 leaves R1's room and no one returns until 10:05 pm, when V17 enters to check R1's blood sugar. Video surveillance with audio indicates R1's blood sugar was low at that time and V17 requests a health shake for R1 to drink. At 10:09 pm, V17 pours a health shake into a cup and gives it to R1, who appears to be lethargic. V17 tells R1 she will be back to recheck R1's blood sugar in 30 minutes. Video surveillance shows R1 alone in her room, sipping on the health shake and at 11:01 pm R1 is slowly slumping towards the left side of the recliner, spilling her drink. V17 does not return to R1's room until 11:07 pm. V17 states R1's name three times and then, "Wake up. Really. You need to wake up. You should let them put you to bed. If you are that worse..., do you want me to send you to the hospital? (R1 is not responsive) You gotta wake up. I'm not mad at you, but something is wrong. Did you even drink that stuff? I'm not mad, I'm just worried about you." V17 leaves the room to get R1 a Glucagon injection. By 11:36 pm, R1's blood sugar is back to normal. V17 states to R1, "Ok, we are going to get you up in bed now and change you (referring to her incontinence brief)." R1 was never toileted after her initial request at 8:42 pm.

Video surveillance from R1's room on 5/18/23 at 8:30 pm recorded the following: V21 (Certified Nursing Assistant) enters R1's room. R1 states, "I've had my call light on for an hour." V21 replies, "I'm sorry, but I'm the only one running the floor right now." R1 states, "Well, the thing is,

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I don't know what I'm doing. I have to go to the bathroom." V21 states, "Do you need to go?" R1 replies, "Yes, well there's no green pads in here." V21 states, "I'll have to go to another unit to get some." V21 leaves without toileting R1 and does not return.

On 7/10/23 at 12:29 pm, V2 (Director of Nursing) reviewed the video surveillance from 5/10/23, 5/11/23 and 5/18/23. V2 stated R1 seemed "defeated" in the 5/10/23 video, after staff repeatedly told her to get up on her own without assistance when she needed to toilet. V2 indicated it was as if R1 "gave up" on trying to be toileted. V2 stated she expects more from the staff, that staff clearly need education on "customer service" and not making residents wait to toilet.

Video surveillance of R1's room, submitted by V12, from 6/09/23 and 6/10/23 was reviewed. The videos from R1's room are in segments, due to the surveillance camera being utilized only records when motion is detected in the room. The video surveillance recorded the following: On 6/09/23 at 9:09 pm, V4 (Licensed Practical Nurse) is at R1's bedside with her back to the camera. R1 is lying in bed and the call light is hanging from the wall, over the nightstand and on the floor. V4 states, "Your accucheck is 291. I'm going to grab your insulin. I'll be back." V4 turns off the light as she leaves the room. Motion is not detected in R1's room again until 6/10/23 at 1:13 am. At that time, R1 is positioned on her right side in bed, facing the right bed rail. R1's call light remains on the floor in the same spot. R1 raises the head of the bed with the button on the bed rail to approximately a 70-degree angle. At 5:25 am, (Which was when V12 woke up and checked on R1 through the video camera. This

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allowed V12 to save the footage she had just viewed even though there was no motion at that time.) R1's head of the bed is in the same upright position, two pillows are on top of R1's lower to mid back, and R1's head is over the right side of the bed towards the ground. R1's upper body is partially against the bed rail. R1 is motionless and R1's call light is still on the floor in the same position. Between 5:26 am and 5:45 am, R1 remained in the same position over the right side of the bed. R1's left arm can be seen moving on two occasions and muffled, inaudible noises are coming from R1. At 5:46 am, V12, V5 (Certified Nursing Assistant) and V10(Agency Certified Nursing Assistant) enter R1's room, R1 is in the same position over the right side of the bed. V5 lowers the head of R1's bed and V10 assists V5 to get R1 positioned back to the center of the bed on her back. V12 is crying and states, "Why has nobody been in here?" V5 responds, "I have been. I walked by all night checking on her. I promise." V12 replies, "She's been like this since one in the morning. It's on camera." By 6:25 am, a licensed nurse has yet to be in R1's room to assess her and V12 remained at R1's bedside. R1 remains unresponsive. V12 states to R1 that she is going to go get a nurse to check R1's blood sugar. At 6:26 am, V7 (Licensed Practical Nurse) enters R1's room to obtain R1's blood sugar. V12 clearly tells V7 that staff have not been in R1's room since 9:00 pm (on 6/09/23). V7 responds, "Yeah, that's horrible. The Director of Nursing will be down to talk to you." V7 then tells V12 that R1's blood sugar reading was "high, so off the charts." At 6:29 am, V12 can be seen showing V7 video surveillance of R1 from the night before and V7 questions V12 if she observed R1 in any distress. At 6:44 am, V3 (Assistant Director of Nursing) enters R1's room as V12 remains at R1's bedside to administer

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R1's insulin. V12 states to V3, "She (R1) hasn't been responsive since I've been here. That was about five something, but no one has been in here since 9:00 (pm). I got up after 5:00 (am). I'll show you the picture of the snapshot of the camera of how (R1) was and I called up here and no one answered, and I came over here." V12 then showed V3 video footage of R1 on her phone. At 6:45 am, V3 states to V12, "The nurse down here was escorted out of the building last night." V12 replies, "Because of this, or because of something else?" V3 then stated, "Just kind of in general. She's been here more than once. She's not one of our employees, but that doesn't mean anything, because she's not coming back. I apologize, also. I had not gotten report since she wasn't here, and I was not aware she went home."

On 6/27/23 at 1:05 pm, V5 (Certified Nursing Assistant) stated the early morning of 6/10/23, she heard someone running and yelling down the hallway. V5 indicated she was in a resident room at the time, so she came out and saw V12 was who was yelling. V12 told her R1 had fallen. V5 stated she and V10 (Certified Nursing Assistant) immediately went into R1's room, where she saw R1 "slumped over, the head of the bed was really high up, like at a 70-80 degree angle. Part of (R1) was leaning into the bed rail, but she was not on the floor. I didn't notice where her call light was, but she didn't use it all night. It should have been clipped to her or tied to the rail. We got (R1) upright into bed and she wasn't really awake but seemed ok. I told the girls in report what happened. (V12) was really upset and said nobody had been in to check on (R1) all night. (R1) was already in bed when I came on shift at 6:00 pm (6/09/23). Around 7:00 pm was the first time I saw her, and she was resting. They told

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me she had just went on Hospice. I went by her room again around 2:30 am (6/10/23) and she was lying flat in the bed, not with her head of the bed way up like we found her. I just peeked into her doorway; I didn't step into the room. We were really busy that night. The Nurse on the floor had been sleeping all night. From around 9:00 pm to 2:00 am, (V4/Licensed Practical Nurse) was sleeping at the nurses' station. Then (V4) got up, went into the common area and slept there from 2:15 am until 5:15 am (6/10/23). I tried to let her know when residents needed something, but she wouldn't wake up." V5 indicated the closer it got to 5:00 am and she could not get V4 to wake up, she knew she needed to notify someone. V5 stated, "I had called (V6/Licensed Practical Nurse) just before 5:00 am, because (V6) was the House Supervisor, but she was working on another floor. I knew the 5:00 am meds were going to need to be passed and I could not get (V4) to wake up. (V6) came up and had to shake (V4) to get her to come around." V5 was questioned as to why she didn't notify management earlier that V4 had slept through the majority of her shift and V5 stated "I didn't want to get anyone in trouble."

On 6/28/23 at 5:50 pm, V10 (Agency Certified Nursing Assistant) stated she started her 12 hour shift on 6/09/23 at 6;00 pm. V10 stated V4 was late coming in to start the shift and as soon as V4 got there, she sat down at the nurses' station and ate her dinner. V10 stated, "After that, (V5) left to get (V4) something from the gas station. (V4) passed her evening (medication) and after that she went to sleep. It was probably around 9:00 - 9:15 pm, she went to sleep at the nurses' station. (V5) and I split up the residents to do their check and change every two hours. I did help (V5) with (R3), just to reposition him. (R3) was in the

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process of dying that night, his breathing had changed, and he was making some sounds. (V5) and I did our last rounds around 4:00 am. (V4) was sleeping in another spot, in a chair then. I never saw (R4) go into a resident room after she did her 9:00 pm med (medication) pass. Near the end of the shift, (R1's) daughter was yelling in the hallway that (R1) was on the floor. (V5) and I went into (R1's) room right away. (R1) was hanging halfway off the bed with her head towards the floor. The head of the bed was way high up and the bed was in the highest position. I don't know how it go that way; I didn't go into to her room that night. (V5) and I got (R1) up in the bed, but she seemed asleep. I don't know (R1) well, so I wasn't sure if that was how she normally was. I've worked with (V4) before and she tends to sleep during her shift and not help, but CNAs (Certified Nursing Assistants) do their thing and Nurses do theirs."

On 6/28/23 at 12:15 pm, V6 (Licensed Practical Nurse) stated on 6/10/23 at about 4:40 am, V5 called her and said the nurse on the 3rd floor was sleeping. V6 indicated she finished her tasks on her floor and got to the 3rd floor about 5:00 am. V6 stated, "I found (V4) sleeping in the chair and out cold. I tried to wake her and shook her by her shoulders. She finally came around. I got her keys and asked her to leave the building. (V5) told me that (V4) had been sleeping all night. I was concerned because there were two residents on Hospice that hadn't been checked on by a Nurse throughout the night. It was (R1) and a male resident (R3)." V6 stated she called V3 (Assistant Director of Nursing) after V4 left the building and informed V3 she had to make a nurse leave for sleeping while on duty. V6 stated, "(V5) called because the morning meds (medication) needed passed, but I was more

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concerned about checking the two residents dying (R1 and R3)." V6 stated, around 5:45 am, "I heard (R1's) daughter in the hall, very upset saying her Mom was on the floor or almost on the floor. I called (V3) again and told her (R1) daughter was upset. (V3) was walking into the building at that time and said she would check on (R1). There were some other residents on that floor I was concerned about, ones that need nursing attention during the night. (R1) is a very brittle diabetic and a fall risk, so she was one. (R4) needs a lot of attention at night, too. I had heard on occasion from day shift staff that (V4) would do her morning med pass late, like she would still be doing it when they came in at 6:00 am, but I didn't' witness that so I never reported it."

On 6/27/23 at 2:06 pm, V3 (Assistant Director of Nursing) stated she was on call the weekend of 6/09/23. V3 indicated she received a call on 6/10/23 at approximately 4:30 am from V6, who advised her there was an issue on the 3rd floor and she sent the nurse (V4) home for sleeping on duty. V3 stated, "(V6) told me the Aides tried to wake (V4) and couldn't, so she went to the floor and had to physically shake (V4) to wake her up. I was coming in to work the floor at 6:00 am and I wasn't sure what (V4) had done or had not done the prior shift. I just knew another nurse was covering the morning med pass. When I got to the floor, (V7/Licensed Practical Nurse) said she had checked (R1's) blood sugar, which was just reading "high". I called (V14/Medical Director) who ordered 20 (Units) of fast acting insulin. After giving it, (R1's) blood sugar was 495. I contacted the on call doctor and the Hospice staff, but the hospice staff informed me (R1's) family was taking her home that day. I know the daughter was upset with her mom's care during

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the night and said staff didn't monitor her as they should have. The aides should have been checking on R1 at least every two hours. We did apologize and advised (V4) would not be returning to work there. (V5) told me that (R1's) family thought (R1) had fallen on the floor, but she hadn't. (V5) told me she checked in on (R1) between 3:30 and 4:00 am (6/10/23). I did question (V6) why (V4) was left to sleep for so long. (V6) said the CNAs (Certified Nursing Assistants) were very frustrated with the fact that they couldn't get the nurse to function, but they reported it was essentially a normal night. I was told (V4) showed up late and had a pillow and blankets where she was sleeping." V3 was questioned if (V4) sleeping throughout the night on her shift could have led to a neglectful situation and V3 stated she did not consider resident neglect at that time, so it wasn't reported as such to the Administration. V3 concluded that if resident's didn't get medication or assessed properly during the night, it would be neglect.

On 6/27/23 at 1:47 pm, V7 (Licensed Practical Nurse) stated she was on day shift 6/10/23. V7 stated when she started the shift, "I was asked to check (R1's) blood sugar because she was lethargic. When I saw (R1), she wasn't talking, but she was awake. (R1) had a blank stare and definitely was not as alert as usual. The Aides told me to let (V3) know, since she was her actual nurse for the day. (V3) told R1's daughter they could not send (R1) to the ER (Emergency Room) because she was on Hospice. I was told that (V4) had slept all night and didn't check on the residents. I heard the Aides tried to wake her that night and couldn't and (V6) had to actually shake (V4) to get her to wake up. I've worked as an Agency nurse with (V4) at other facilities. (V4's) been known to sleep on the job and has

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been caught using drugs in the bathroom while working other places. (V4) sleeps on shift all of the time and she's done it at numerous facilities. When she's on the schedule, she's a body and that's all."

On 7/07/23 at 7:53 am, V16 (Nurse Practitioner) stated R1 had been "progressing downhill" medically. V16 stated, "On June 1st (2023), (V12) expressed to me she was having issues with staff not toileting (R1) routinely. So, I told (V6/Licensed Practical Nurse) that I wanted someone checking on her (R1) every two hours. (R1) should have been on a every two hour check and change. (R1) was a brittle Diabetic and was not the most compliant, but (V4) not returning to give (R1) her insulin is a huge problem. Staff not checking on (R1) every two hours is a huge problem. Someone should have been in that room during the night." V16 (Nurse Practitioner) stated "It doesn't matter where staff are in their education, they can do things for the residents, like pass ice and toilet them, get them what they need." V16 concluded that R1 had "been progressing downhill" and staff often don't understand that residents decline and can't do the things they used to do for themselves independently anymore.

2. The Electronic Medical Record documents R3 was admitted to the facility on 2/23/23 for Hospice services related to Malignant Neoplasm of the Colon. A 5/25/23 Pain Evaluation documents R3 as experiencing daily moderate pain in his back related to metastatic cancer and he receives narcotics. R3's Hospice Care Plan, dated 6/01/23, documents R3 was experiencing a significant decline and identifies the following: Goal is for pain to be controlled with R1's desired comfort level, Initiate comfort medications for

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symptom management, Staff are to collaborate with the Primary Nurse regarding R1's condition and Ensure and coordinate provision of care and services meet R1's needs. On 6/08/23, Physician's Orders document Hospice changed R3's medication orders to the following: Lorazepam 0.5 mg every four hours for end stage restlessness, Atropine Sulfate 1% two drops orally every two hours for oral secretions, Morphine 20mg/ml 0.75 ml (milliliters) every four hours for pain and instructed staff to continue to assess and document R3's pain level twice per day on day shift and night shift.

On 6/09/23 at 8:49 am, Nursing Progress Notes document, "Sponge bath given in bed, area to hips cleaned with (normal saline) all even covering. (R3) actively dying, turned every couple hours, air mattress on bed, area on feet and shoulders pinkish in color not open at this time." There are no documented Nursing Progress Notes for R3 during the afternoon or night of 6/09/23 or the morning of 6/10/23.

On 6/28/23 at 5:50 pm, V10 (Agency Certified Nursing Assistant) stated "(V4) passed her evening (medication) and after that she went to sleep. It was probably around 9:00 - 9:15 pm, she went to sleep at the nurses' station. (V5) and I split up the residents to do their check and change every two hours. I did help (V5) with (R3), just to reposition him. (R3) was in the process of dying that night, his breathing had changed, and he was making some sounds. (V5) and I did our last rounds around 4:00 am."

On 6/28/23 at 12:50 pm, V5 (Certified Nursing Assistant) stated she was aware the evening of 6/09/23 that R3 was on Hospice and in the end stages of life. V5 stated, " We did turn (R3) every

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two hours as much as we could. He had a wound that he needed to stay off of. (R3) was on Hospice and actively dying that night, so we focused on keeping him comfortable. He had a lot of stuff in and around his mouth, so we tried to clean that up. I never saw (V4) go into his room during the night. Like I said, she was sleeping the whole time."

On 6/28/23 at 12:15 pm, V6 (Licensed Practical Nurse) stated on 6/10/23, at about 4:40 am, V5 called her and said the nurse on the 3rd floor was sleeping throughout the night. V5 indicated she was aware that there were Hospice patients on the 3rd floor, and she was concerned they hadn't been checked on by a Nurse throughout the night." V6 stated, "(V5) called because the morning meds (medication) needed passed, but I was more concerned about checking the two residents dying (R1 and R3). I went to the gentleman's room first (R3). The gentleman passing (R3) was having extreme air hunger and lots of oral secretions. His eyes were fixed, and he seemed to be just hanging on. I wouldn't want to die like that. I immediately gave him Atropine, Morphine and Ativan. I had another nurse pass the morning meds." At that time, V6 was questioned regarding a documented Pain Assessment in R3's Medication Administration Record on the evening of 6/09/23, where V6 initialed R3's pain was at a "7" on a scale of 1-10. V6 confirmed at that time, she back dated that pain assessment on R3 to 6/09/23 and that was actually R3's level of pain when she arrived to his room on 6/10/23 at approximately 5:15 am.

Medication Administration Records document V4 charted she administered Lorazepam 0.5 mg and Morphine 0.75 ml to R3 at 8:00 pm and midnight on 6/09/23, when V5 and V10 had observed V4 to

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be sleeping all night. Documentation indicates R1 did not receive any Atropine Sulfate 1% for terminal/oral secretions on 6/09/23 or 6/10/23. However, On 7/10/23 at 2:40 pm, V2 (Director of Nursing) stated she completed a narcotic count as a part of her investigation into resident neglect due to V4 sleeping throughout her shift on 6/09/23-6/10/23. V2 stated she was able to confirm that V4 did not administer Lorazepam 0.5 mg and Morphine 0.75 ml to R3 at midnight on 6/09/23, even though V4 documented in the Medication Administration Record that she did.

On 7/07/23 at 7:53 am, V16 (Nurse Practitioner) stated a patient on Hospice and near the end of life should be assessed by the Licensed Nurse frequently, "we want these people to be comfortable, oral care needs to be given, assessed for pain. The nurse (V4) not checking on (R3), making sure his medical needs are met in the dying stages is 100% neglect." V16 stated she would expect the nurse to be completing and charting ongoing pain assessment and if the medications being administered at the end of life are being effective or not. V16 stated, if R3 did not receive medication as ordered at midnight on 6/10/23, that could account for why he was experiencing air hunger and pain when V6 assessed him after 5:00 am on 6/10/23.

On 6/28/23 at 12:30 pm, V3 (day shift Nurse/Assistant Director of Nursing) stated V5 did report to her the morning of 6/10/23 that R3 had increased secretions throughout the night and V6 did not pass on any information regarding the condition she found R3 in that morning (6/10/23).

The next Nursing Progress Note is on 6/10/2023 at 5:26 pm, "Family has been here with (R3) most

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of the day, Hospice nurse was just in and (saw) resident, she doesn't feel like he will transition over tonight, our goal is to keep him comfortable, he keeps his lips pierced together when giving morphine and Ativan, but this nurse was able to administer it, turned and repositioned often, fingers are cool to touch, his feet are mottling somewhat, will continue to monitor and note changes accordingly." Nursing Progress Notes document R3 expired on 6/11/23 at 9:33 am.

3. The Electronic Medical Record documents R2 has the current diagnoses of Low Back Pain, Pain in the Left Hip and Repeated Falls. R2's Current Plan of Care documents, "I have chronic pain (related to) Low Back Pain. (Complaint of) pain even after scheduled pain meds, this occurs almost daily." The Plan of Care advises staff of the following: Nursing is to anticipate need for pain relief and respond immediately to any complaint of pain, (R1's) pain is alleviated/relieved by as needed Tylenol, Evaluate the effectiveness of pain interventions every shift, R2 is able to call for assistance when in pain, ask for medication, tell you how much pain is experienced, Nursing staff is to monitor/document for side effects of pain medication, monitor/record pain characteristics every shift and as needed, and monitor/record/report to Nurse R2's complaints of pain or requests for pain treatment. R2's current physician orders, dated 6/01/23 document R2 can received Tylenol 500 mg (milligrams) every 6-8 hours for breakthrough pain and instructs staff to assess R2's pain in the morning and at night. A Minimum Data Assessment, dated 4/12/23, documents R2 has a BIMS (Brief Interview of Mental Status) of 11, suggesting R2 has moderate cognitive impairment, but is able to make her needs known.

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On 6/27/23 at 1:05 pm, V5 (Certified Nursing Assistant) stated she recalled R2 asking for pain medication during the night of 6/10/23. V5 stated she could not recall what kind of pain R2 was having, but she tried to notify V4 (Licensed Practical Nurse) of R2's request for pain medication; however, V4 would not wake up at that time. V5 stated "I know (R2) didn't' get it (pain medication)."

On 6/29/23 at 10:52 am, R2 was questioned about her pain and if she had recently gone without pain medication after requesting it. Due to R2's cognition, she was unable to cite anything specific, but stated, "There are times it gets missed." R2 stated she will often ask for additional pain medication during the night because she had pain in her hip. R2 stated, "I get pain there (pointing to her hip) when I lay in bed, it's like an ache and the Tylenol will help me go back to sleep."

The Electronic Medication Administration Record documents staff failed to assess R2's pain level on the night of 6/09/23 and R2 did not receive any PRN (as needed) Tylenol 500 mg on 6/09/23 or 6/10/23.

On 6/28/23 at 2:30 pm, V2 (Director of Nursing) stated V3 and V1 (Assistant Administrator) were in charge of the building that weekend, as she was off. V2 stated she didn't find out anything about what happened that weekend until Monday (6/12/23). V2 indicated she heard "(R1's) Daughter was upset over her Mom's care and (V3) was handling it. I'm just now hearing the whole story." V2 stated she would have expected the Aides to let someone know well before 4:40 am that V4 had been sleeping on shift. V2

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concluded, if residents were not getting proper care or receiving medication that night, she would consider that patient neglect.

On 6/28/23 at 2:42 pm, V1 (Acting Administrator) stated the only thing she was notified of that weekend, was on the evening of 6/10/23. V1 stated she was told a Hospice patient was going home with family and that very early in the morning staff had found an Agency Nurse sleeping and she was immediately sent home. V1 stated, "I was told nothing more. On Monday, I contacted the Staffing Agency and told them (V4) was found sleeping and was difficult to arouse. I asked for (V4) to be put on a Do Not Return list for our facility." V1 was unaware if anyone in management had officially spoken with or interviewed the CNAs that found V4 sleeping that night. V1 stated, "I am just learning all of the details from that night and had I been aware, it would have been looked into for Neglect." On 6/29/23 at 10:15 am, V1 confirmed that there had been no abuse or neglect allegations reported to her or management regarding the night in question.

(A)

2 of 2

300.610a)
300.1210b)4)
300.1210d)3)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the

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facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the

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following and shall be practiced on a 24-hour, seven-day-a-week basis:

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.

These requirments are not met as evidenced by:

Based on record review and interview, the facility failed to obtain an order for use of bed rails, assess bed rails for safety when used with a low air loss mattress, obtain informed consent and review risks/benefits of bed rail use with the resident's representative for one of one resident reviewed for bed rails in a sample of 32. The facility failed to develop a system for notifying Maintenance of mattress changes when bed rails are being used, so a new Entrapment Risk Assessment could be completed to ensure safety prior to resident use. This failure resulted in R1 rolling out of her bed on 6/08/23 and her head becoming entrapped between the mattress and the bed rail. Facility staff continued to use R1's bed rails in the upright position after R1 became entrapped. On 6/10/23, R1 was found with her upper body hanging over the side of the bed against the bed rails. R1 continued to have bed rails on her bed until she discharged to home on hospice 6/10/23.

Findings include:

The Recommendations for Health Care Providers Using Adult Bed Rails by the United States Food and Drug Administration

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(https://www.fda.gov/medical-devices/adult-portable-bed-rail-safety/recommendations-health-care-providers-using-adult-portable-bed-rails) include the following, "When installing and using bed rails: Select an appropriate bed rail for age, size and weight of the person using the bed rail. Be aware that not all bed rails, mattresses, and bed frames are interchangeable and not all bed rails fit all beds. Check with the manufacturers to make sure the bed rails, mattress, and bed frame are compatible. Follow the health care facility's procedures and manufacturer's recommendations and specifications for installing and maintaining bed rails for the particular bed frame and bed rails used. If the bed rail includes a safety strap or bed rail retention system, ensure these are attached to the rail and secured to the bed frame according to the manufacturer's instructions. Use caution when using bed rails with a soft mattress as this may increase risk of entrapment between the mattress and bed rail. Inspect and regularly check the mattress and bed rails to make sure they are still installed correctly and for areas of possible entrapment and falls. Regardless of mattress width, length, and depth, the bed frame, bed rail, and mattress should leave no gap wide enough to entrap a patient's head or body. Regularly assess that bed rails remain appropriately matched to the equipment and to the patient's needs, considering all relevant risk factors. Inspect, evaluate, maintain, and upgrade equipment (beds, mattresses, and bed rails) to identify and remove potential fall and entrapment hazards. Re-assess the person's needs and re-evaluate the equipment if an episode of entrapment or near-entrapment occurs, with or without serious injury. This should be done immediately because fatal 'repeat' events can occur within minutes of the first episode. Be aware that gaps can be created by

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movement or compression of the mattress which may be caused by patient weight, patient movement or bed position, or by using a specialty mattress, such as an air mattress, mattress pad or waterbed. When in doubt, call the manufacturer of the bed rails for assistance."

The facility policy, titled Policy and Procedure for Safe Use of Bedrails (no date) documents, "The purpose of this guidance is to provide a uniform set of recommendations for caregivers in Sunset Home care settings to use when assessing their patients' need for possible use of bed rails. Bed rails can facilitate turning and repositioning within the bed or transferring in or out of a bed. Procedures: 1. The use of bed side rails must first be evaluated for their appropriateness upon admission in relation to the resident's condition. 2. The request for half or full bed rails must be made by either the Physician/resident &/or POA (Power of Attorney) and clearly documented in the service plan. The facility must obtain a physician's order which needs to be kept on file in the resident's chart. 3. The resident &/or POA must be advised of the risks of bed side rails, including the possible dangers associated with their use prior to the implementation. 4. The continued use of bed side rails must be assessed for appropriateness quarterly as part of updating the resident's service plan, or more often as necessary, with significant changes."

R1's electronic medical record documents R1 was admitted to the facility on 5/26/21 and has the current diagnoses of Chronic Pain, Type II Diabetes Mellitus with Hyperglycemia, History of Diabetic Ketoacidosis, Muscle Weakness, Muscle Wasting and Atrophy. A Consent for Use of Side Rails form was signed by R1 on 10/06/21 and a Maintenance Bed Rail Assessment was

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documented as being completed that same day. Bed Rail evaluations, on 1/09/23 and 4/13/23, document R1 as a fall risk, that bed rails would only provide R1 with a sense of security, and that bed rails were not indicated at that time as neither R1 or R1's family was requesting the use of bed rails. R1's current Plan of Care documents, "I am high risk for falls (related to) gait/balance problems" and instructs staff to provide "a working and reachable call light, the bed in low position at night; personal items within reach." R1's current Physician's orders, dated 6/01/23, do not contain an order for the use of bed rails. Per interview with V3 (Assistant Director of Nursing), on 6/29/23 at 2:41 pm, R1's mattress was changed to a Low Air Loss Mattress due to her decline in health, with no change in R1's bed frame. Hospice Admission documentation, dated 6/08/23, indicates R1 was placed on Hospice Services due to a physical decline related to malnutrition and cites R1 has experienced increased confusion over the last six months. R1's Hospice Plan of Care, dated 6/08/23, documents under "Mobility/Safety" that R1/Caregivers will "demonstrate safe, effective use of equipment. Interventions: Instruct Patient/Caregiver on fall prevention and safety precautions. (R1) requires assistance of two for transfer but has not been out of bed for 2 days prior to Hospice enrollment. Patient is (a) fall risk. Education to keep bed in low position and call light within reach."

On 6/26/23 at 3:04 pm, V12 (Family) stated that R1 has a video camera in her room that is triggered to record with motion or movement. According to V12, on 6/10/12 at 5:25 am, she could "see Mom (R1) dangling over the side of the bed. I tried calling there (facility) to notify the staff and no one answered, it rang and rang. I

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only live 10 minutes away, so I just drove over there. When I got to Mom's floor, it was a ghost town. There were no staff to be seen. I went into her room, and she was still hanging over the side of the bed and her call light was on the floor. So, I went running down the hall looking for someone to help. The Aides came into her room and set her upright. Mom is not waking up and is lethargic." V12 indicated she went back and reviewed video footage to try to determine how long R1 had been hanging over the side of the bed or if she had any other issues, like a fall. V12 stated on 6/08/23 she observed video surveillance of R1's lower body sliding off the bed and her head getting stuck between bed rail and the mattress. V12 concluded, "No one ever called me to even tell me that (had occurred)." V12 was asked if the facility had ever informed her of the risk and benefits of using bed rails prior to installing them on R1's bed and V12 stated a discussion about bed rails was never had with anyone at the facility.

Video surveillance from R1's room, dated 6/08/23 at 10:38 am captured the following on 6/08/23 at 10:38 am: R1 is lying on her left side, positioned on the far left side of the bed. R1 is on a low air loss mattress with both 1/4 bed rails in the upright position. R1's legs begin to slowly slide off the left side of the bed towards the ground, pulling her upper body into the bed rail. R1 attempts to sit up, but her lower body is over the side of the bed, this brings her head and upper body and further into the space between the mattress and bed rail. R1 is in this position for approximately 25 seconds, when V13 (Certified Nursing Assistant) enters R1's room and says toward the hallway, "Get the Nurse. She's (R1) on the floor." V13 attempts to move R1 by herself but is unsuccessful. At 10:41 am, V15 (Certified

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Nursing Assistant) enters the room to assist V13 and V13 states, "Her (R1) head's stuck between there." V11 (Licensed Practical Nurse/Unit Coordinator) enters the room and lowers the head of the bed, which allows the staff to get R1 out of the space between the mattress and bed rail and R1 is then fully lowered to the ground. V11 briefly assesses R1 and then V11 and V13 assist R1 back to bed.

R1's Electronic Medical Record contains no documentation (Nursing Progress Note, Care Plan Revision, Incident Report, Physician Notification, etc.) of R1 sliding out of bed on 6/08/23, causing her head to become entrapped between the mattress and bed rail.

On 6/28/23, V1 (Acting Administrator) and V2 (Director of Nursing) were asked if they had any incident reports for R1 from June 2023, and they both indicated they did not.

On 6/29/23 at 12:49 pm, V13 (Certified Nursing Assistant) stated she just happened to be walking by R1's room (on 6/08/23), doing rounds, and saw R1 hanging from the bed. V13 stated, "I was the first one in the room. (R1's) head and shoulder was wedged between the air mattress and side rail. (R1's) legs were on the ground. I could see (R1's) face was pressing up against the side rail. It took three staff to get (R1) out and lower her to the ground." V13 stated R1's bed rails were not lowered for her safety after the incident.

On 6/29/23 at 12:10 pm, V11 (Licensed Practical Nurse) stated she was called in to help V13 after R1 had "slid out of the bed and onto her knees." V11 stated she didn't see R1 by the bed rail or entrapped between the bed rail and the mattress.

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V11 stated R1 was not injured or complaining of pain. V13 stated "(R1) typically doesn't try to get out of bed and she always uses her call light. After that happened, I had a tab alarm placed on (R1) and told the aides to put foam noodles on both sides of the bed." V11 stated she did not discontinue R1's bed rails. V11 stated she did a report in "Risk Watch" to tell management what happened with the fall and "myself or the MDS (Minimum Data Set) Coordinator" would have been responsible for updating R1's care plan with fall interventions. V11 stated she was working when R1 received the new air loss mattress (6/06/23) and stated R1 had a regular mattress prior to that. V11 stated she did not think there was any reason why R1 couldn't have bed rails with the low air loss mattress. V11 then concluded, "The Maintenance Department does routine entrapment risk assessments on all beds with side rails. But I didn't request a new one from Maintenance when (R1's) new mattress was put in place (on 6/06/23)."

On 6/29/23 at 10:15 am, V1 (Acting Administrator) confirmed again that Management had not been notified of R1 experiencing any recent falls from bed or that R1 had become entrapped in the bed rails. At that time, the video of R1 on 6/08/23 falling was reviewed with V1. After reviewing the full video of R1's incident, V1 agreed that it should have been investigated as a fall from bed with entrapment. V1 stated R1 should have had a physician's order for the side rails and an accurate bed rail risk assessment completed prior to using bed rails with the low air loss mattress.

On 7/06/23, V2 (Director of Nursing) she was unaware of R1 had slid off the bed or become entrapped between the bed rail and mattress until

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it was brought to their attention during the survey. V2 stated the Maintenance Department is to be doing Entrapment Risk Assessments, which included gap measurements, on all beds with bed rails, quarterly and they do monthly rounds to check for any residents that might be new and using bed rails. V2 stated there is no policy or routine practice of staff requesting maintenance to measure for entrapment risk when a resident has a mattress change. V2 indicated she had reviewed R1's Bed Rail evaluations from 1/09/23 and 4/13/23 and noted that those assessments did not support R1's use of bed rails and that R1 did not have a physician's order for the use of bed rails. V2 stated, "(R1) was at one point alert and oriented enough to use (bed rails) for mobility and transfers, but I'm not sure about the end when she had declined." V2 then stated, V11 had completed a paper Incident Report on 6/08/23, but V11 never entered the information into the computer for V1 to be notified of what had occurred. V2 stated V11 should have completed a Nursing Note in the electronic medical record, which would have notified Risk Management, but that information wasn't entered, which is why she wasn't alerted to do an investigation. At that time, V2 provided the paper Incident Report completed by V11 on 6/08/23. This Resident Incident Report, dated 6/08/23 at 10:00 am, by V11 documents R1 was found at 9:15 am on 6/08/23 and "Describe: found (R1) sliding out of bed." The report documents R1 sustained no injury, was assessed and returned to bed. The report also documents V12 and V16 (Nurse Practitioner) as being notified of the incident. This report fails to document that R1's head was between the bed rail and mattress.

Additional video surveillance was reviewed and on 6/10/23 from 5:26 am and 5:46 am R1 can be

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S9999	Continued From page 34 seen with her head over the right side of the bed towards the ground and both bed rails are in the upright position. R1's upper body is partially against the bed rail. R1 is motionless and R1's call light is on the floor. At 5:46 am (6/10/23), V12, V5 (Certified Nursing Assistant) and V10 (Certified Nursing Assistant) enter R1's room and she is assisted to an upright position. On 7/07/23 at 7:53 am, V16 (Nurse Practitioner) stated she was not notified of R1's 6/08/23 fall and entrapment and indicated she was on vacation that week. V16 stated she did not find out about the incident until after R1 had passed away. V16 stated, if she had been notified of the incident immediately after it happened, she would have told staff to discontinue using the bed rails. (B)	S9999		