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
	IL6004139	A. BUILDING: ______ B. WING ______	C 11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER HEALTH CARE CENTER	15600 SOUTH HONORE STREET HARVEY, IL 60426

(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 FRI of 7/1/2023/IL162289, Complaint Surveys: 2395435/IL161573, 2398154/IL164984, & 2397830/IL164584	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 1. 300.610a) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care	S9999	Attachment A Statement of [illegible]	

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

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

Section 300.3240 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)

These Requirements were not met as evidenced by:

Based on interview and record review, the facility failed to follow their Abuse Prevention Policy by not keeping residents free from physical and verbal/mental abused by staff. These failures applied to two (R15, R19) of seven residents reviewed for abuse and resulted in R15 experiencing mental abuse by feeling retaliated against by a staff member and R19 was physically abused by staff hitting R19 with a hanger to the right buttock, leaving a red discoloration.

Findings include:

R19 is a 72 year old male admitted to the facility 7/17/2020 with diagnoses of Alcohol abuse with alcohol-induced anxiety disorder, Unspecified Dementia, Hypertension and dysphagia. According to R19's health record, he is dependent on staff for activities of daily living.

On 9/16/23 R19 made an allegation of physical abuse against V4 CNA. Progress note dated 9/16/23 stated, "The writer was at the nurse's station and heard a loud popping sound and I traced the sound in the hallway. I then saw the

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S9999	Continued From page 2 above resident frantically stumbling toward his bed and I asked him if he is ok and then he stated "The CNA hit me " I stat pulled the cna off the floor and approached her at the nursing station in regard to the accusation. The assistant administrator/MOD [Manager on Duty] at that time was notified immediately. Administrator, POA (Power of Attorney), Don [Director of Nursing], Np [Nurse Practitioner], and [Medical Doctor] made aware. I immediately did a full body assessment on the resident, and I observed a red discoloration on the Rt buttock. The resident denies pain and refuses pain medication at this time." This incident was reviewed and investigated by V1 Administrator shortly after the incident occurred. On 10/31/23 at 11:44AM V1 said when the event occurred, the assistant administrator was on duty and in the building. V39 Assistant Administrator removed V4 from the building immediately and called me. He said, there was an allegation which V4 admitted to. I came to the facility shortly after and began my investigation. I interviewed V4 a few days later and she admitted to hitting R19 with the hanger as well. I told her that she was terminated for not adhering to the abuse policy. She did not return to the facility since the incident occurred. Facility Abuse Policy revised 9/2020 states in part; This facility affirms the right of our resident to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. The facility will report reasonable suspicion of a crime. This facility therefore prohibits mistreatment, neglect or abuse of its residents and has attempted to establish a resident sensitive and resident secure	S9999		

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environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. This will be done by: 3. Establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment.

This facility is committed to protecting our resident from abuse by anyone including, but not limited tom facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends or any other individuals. This facility will not knowingly employ individuals who have been convicted of abusing, neglecting or mistreating individual.

Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility. Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. Willful mean the individual acted deliberately, not that the individual must have intended the injury or harm. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain and /or maintain physical, mental and psychosocial well-being. This includes suspicion of a crime. Assuring that physical restraints re used sparingly and properly and that chemical restraints are not used. This assumes that all instances of abuse of resident, even those in a coma cause physical harm or pain or mental anguish.

R15 is a 49-year-old male with a diagnoses history of Recurrent Major Depressive Disorder, Unspecified Convulsions, End Stage Renal

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S9999	Continued From page 4 Disease, Type II Diabetes Mellitus with Complications, Diaper Dermatitis (August 2023), Legal Blindness, and Amputations of Fingers and Lower Limbs who was admitted to the facility 07/31/2017. R15's current care plan initiated 07/20/2022 has a history of physical aggression towards others due to poor impulse control with interventions including validated his feelings and ensured his safety; remove resident form any potential situation which could precipitate aggressive behavior. Final Facility Reported Investigation Report dated 05/13/2023 documents on 05/03/2023 a staff member reported that R15 made an allegation of abuse toward a staff member with the specific allegation against staff being unclear in the report; documents his allegations were inconsistent and range from verbal abuse to denying all allegations; R15 reported that he thought a staff member was speaking about him in the hallway about him not needing any help with his care; The CNA (Certified Nursing Assistant) in question (name not included in report) was interviewed by the charge nurses regarding R15's claims that he requires no assistance and when the CNA asked R15 if he had any concerns about his care he became verbally abusive, used profanity against the staff and requested she leave his room stating he does not want her to provide him with care; R15 has a history of false allegations and verbal aggression toward staff; Staff denied witnessing any form of abuse against R15; R15 did not have any roommates at the time of the alleged incident; R15's provided inconsistent accounts of the alleged incident; The allegation was not substantiated.	S9999		

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Investigation statement dated 05/03/2023 documents R15 reported that V31 (Certified Nursing Assistant) was negligent in her care towards him, she never brought him his food and he heard her in the hallway stating R16 was "bitching about his food," to another CNA and when he confronted her she stated she was just playing with him; R15 then reported another incident in which he asked her to go to his closet and give him a shirt out of his bag and she told him that she wasn't going to do it because these were too many clothes to go through so first shift staff can do it.

R15's investigation statement dated 05/03/2023 documents V31 (Certified Nursing Assistant) went off on him because he reported to V33 (Certified Nursing Assistant) that she won't change him or give him his food and the CNA stated she didn't appreciate him informing V33; R15 felt it was retaliation from reporting her to V33.

Investigation statement dated 05/04/2023 documents V27 (Licensed Practical Nurse) reported V33 CNA (Certified Nursing Assistant) came to report how rude and unruly the CNA was with herself, the nurse on duty and the resident and V27 advised she write a statement and leave it with the Director of Nursing.

Resident Post Occurrence Follow Up report dated 05/12/2023 documents R15 reported his CNA approached him asking if everything is ok and asked if he told people that she's not doing her job, he didn't appreciate her questioning him, so he went off on her.

Investigation statement dated 05/03/2023 from V33 (Certified Nursing Assistant) documents Attn

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S9999	Continued From page 6 V34 (Former Director of Nursing): Today R15 asked me to report V31 (Certified Nursing Assistant) negligent behavior towards him, he stated that she never brought him his food and he heard her in the hallway stating R16 was "bitching about his food," to another CNA and when he confronted her she stated she was just playing with him; R15 then reported another incident in which he asked her to go to his closet and hive him a shirt out of his bag and she told him that she wasn't going to do it because these were too many clothes to go through so first shift staff can do it. R15 states that he doesn't want her to come in his room or care for him, upon notifying V32 (Registered Nurse) of what R15 stated V31 walks up and asks if R15 was talking about her and what was said, I asked V32 if it was ok to repeat what R15 stated and he said it was ok, upon hearing what R15 had to say V31 went in the room and confronted him and made him furious, I went in the room and calmed him down, moments later she walked in to another 1st floor room and stated she is "gonna spaz out on everybody report people to the state and anybody can get it just loud unprofessional and rude," I spoke to V27 (Licensed Practical Nurse) about this and she advised to inform you (V32). On 11/01/2023 from 12:16 PM - 2:10 PM V1 (Administrator) stated V33 (Certified Nursing Assistant) initially reported R15's allegation regarding V31 (Certified Nursing Assistant). V1 stated the investigation report documents V31 stated to R15 regarding his allegation, "did you tell people that I wasn't doing my job," but V31 was not hostile or confrontational when using those words and asking that question. V1 stated she could see it being offensive for a resident to be asked that question by staff. V1 stated V31 wasn't privy to R15's history of being aggressive	S9999		

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and hostile towards staff because that wasn't her experience with him. V1 stated staff are responsible to familiarize themselves with residents based on their care plans. V1 stated it's not appropriate for staff to ask residents about allegations made against them and it could trigger R15. V1 stated she would train staff on resident rights and behavior management to address these issues.

On 11/01/2023 at 2:45 PM V1 (Administrator) stated it is subjective as to whether a resident would feel intimidated by staff when being asked about an allegation the resident reported against them.

The facility's Abuse Policy reviewed 11/02/2023 states:
"This facility affirms the right of our residents to be free from abuse. This facility prohibits mistreatment or abuse of it's residents and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment or abuse of our residents. This will be done by:
Establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment."

"This facility is committed to protecting our residents from abuse by anyone including but not limited to facility staff."
"Abuse means any mental injury inflicted upon a resident other than by accidental means in a facility. Abuse is intimidation with resulting mental anguish. Willful means the individual acted deliberately, not that the individual must have intended the harm."

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S9999	Continued From page 8 "Mental Abuse may occur through verbal contact which has the potential to cause the resident to experience intimidation, fear, agitation or degradation." "Mistreatment is inappropriate treatment or exploitation of a resident." (B) 2. 300.610a) 300.1210b) 300.1210c) 300.1210d)6 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care	S9999		

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S9999	Continued From page 9 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to re-evaluate fall care plan interventions for effectiveness after resident falls for residents assessed to be at risk of falling, and failed to have individualized interventions, taking resident cognitive function into account, included in the plan of care to meet specific resident needs to address re-current falls. This failure applied to three (R4, R5, R26) of three residents reviewed for falls and resulted in R4 having multiple falls and sustaining a laceration to the forehead, which required sutures; R5 had a fall which resulted in hospitalization for acute intracranial hemorrhage; and R26 having multiple falls and being observed to wander into other resident rooms unsupervised.The facility failed to	S9999		

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keep a resident (R16) free from injury while being provided care by staff and by not implementing effective and personalized fall interventions for a resident (R17) with a history of falls. These failures applied to two (R16, R17) of two residents reviewed for accidents.

Findings include:

R5 is a 75-year-old man who resided at the facility from 4/14/2021 to 11/7/2022, with past medical history of Type 2 diabetes, Heart failure, Hyperlipidemia, Essential Primary Hypertension, Dysphagia, Gastro-Esophageal Reflux disease without Esophagitis, etc.

Per record review, R25 (RN) documented the following on 11/7/2022, resident fell, speech slurred able to lift right and left arm as well as stick tongue out with no deviation, however no improvement in speech. Resident sent out 911.

Hospital record dated 11/7/2022 states in part, 74-year-old male with past medical history of ...presented from a nursing home after an unwitnessed fall. On arrival, CT head showed large acute intracranial hemorrhage with extension to right basal ganglia and 2mm midline shift. Neurosurgery consulted by emergency room physician, their evaluation pending. On my evaluation patient is obtunded, not following any command, occasionally moans to painful stimuli, systolic blood pressure is above 200. Review of death certificate showed that R5 expired on 12/13/2022, cause of death was listed as non-traumatic intracranial hemorrhage.

Care plan initiated 4/14/2021 stated that R5 is at risk for falls related to the use of anti-hypertensive

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medication, unsteady gait, uses walker, requires assistance with toileting. Interventions include assist resident at night when he needs to go to the bathroom, orient resident to surroundings frequently, including location of bathroom, dining room, bedroom, etc., provide proper well-maintained footwear, etc.
The additional intervention after the fall on 6/4/2023 was for resident to request assistance with transfer from staff. Care plan initiated 6/13/2022 stated that resident has limited ability to manage and complete functional tasks due to balance deficit musculoskeletal. Interventions include to assist and instruct resident with all prescribed physician precautions, fall risk education and therapeutic exercises to improve balance ability.

Minimum Date Set (MDS) assessment dated 6/14/2023 section G (functional) coded R5 as requiring staff supervision with set up or one-person physical assistance for all ADLs. Section GG (functional abilities) of the same assessment coded resident as requiring supervision or touching assistance to partial to moderate assistance for ADLs.

On 11/4/2023 at 4:17PM V45 (LPN) said that she recalls R5 and recalls the last time he fell. R5 needed assistance with ADLs, he is incontinent sometimes but other times he goes to the bathroom. The day R5 fell, V45 said that she was working on the other side of the floor, another resident notified her that R5 was on the floor, resident stated that he was going to the bathroom when he fell. R45 added that she does not know the last time resident was seen by a staff before the fall.

On 11/01/2023 at 12:55PM, V25 (RN) said that he

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recalls R5, he was on break the day resident fell, according to the nurse that was covering for him, resident was grabbing something on his dresser and fell, he did not witness the fall.V25 added that R5 has fallen before and he is a fall risk, V25 said that he did not follow up with the hospital after resident was sent out, he did not complete the incident report either because he did not witness the fall, not sure if resident had any injuries.

Fall incident dated 6/4/2022 documented by V26 (LPN) stated that she was made aware resident needed assistance, resident noted sitting next to wall in bedroom with his walker on the floor next to him. Resident stated that he was going to the washroom and lost his balance. R5 also had a fall on 6/4/2022 as documented by V26 (LPN) at 00:32, resident sustained an injury to the back of his head and was also sent to the hospital for further evaluation.

On 11/1/2023 at 12:24PM, V26 (LPN) said that she recalls R5, he can walk, he gets around on his own but requires staff supervision, she does not recall what resident was doing before the fall, she was notified by another resident. V26 cannot recall the last time herself or the CNA saw the resident before he fell.

R26 is a 62-year-old female who was admitted to the facility on 3/24/2023 with past medical history of essential primary hypertension, unspecified dementia, iron deficiency anemia, schizophrenia, generalized muscle weakness, etc.

On 10/31/2023 from 1:25PM to 1:30PM, observed about five residents sitting in one area in the dementia unit eating lunch and there was no staff in sight monitoring or supervising them.

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S9999	Continued From page 13 At 1:32PM, a resident came down from the hallway and stated that another resident came to her room while she was eating and did something in the garbage can on her roommate's side of the bed, she stated that she does not know who the resident is or what room she came from. Surveyor followed resident to her room and observed R26 lying down in the first bed, awake but confused and could not answer any questions, Surveyor also observed some yellowish liquid in the garbage can and on the floor in room. On 10/31/2023 at 1:34PM, V6 (ADON) was spotted in the hallway, surveyor presented this observation to her, and she said that R26 is from (another) room, resident wanders. V6 walked resident back to her room, Surveyor notified V6 that there was some yellowish liquid in the garbage can in room (number provided) and the other resident complained that R26 did something in the garbage can, V6 looked in the garbage can and stated, "that is urine, I will get housekeeping to take care of that, I bet you the other resident did that and is trying to pin it on R26 I don't think she will do something like that." On 10/31/2023 at 1:37PM, V7 (CNA) was observed guiding resident to her room and told surveyor that this resident does that all the time, she wanders into other residents' rooms, pull her pants down and urinates anywhere, she has taken care of the resident for a while, and she does that all the time. Per facility fall log, R26 has had multiple unwitnessed falls since admission (9/6/2023 found on the floor in the dining room; 9/13/2023, another resident informed staff that resident was on the floor in the nursing station; 6/13/2023,	S9999		

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	IL6004139	A. BUILDING: ______ B. WING ______	C 11/03/2023

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resident was found on the floor in the hallway and sustained swelling to the right side of her face).

MDS assessment dated 8/16/2023 section G coded resident as requiring supervision with set up to one-person physical assistance for ADLs.

Fall care plan initiated 6/9/2023 stated that resident is at risk for falls due to poor safety awareness. Interventions include but not limited to encourage resident to keep room free of obstacles, encourage resident to report falls, resident was placed in a unit where she could be more closely monitored and constantly redirected, resident was sent to the hospital for further evaluation, provider was consulted for further evaluation, etc.

R4 is a 74-year-old female who has resided at the facility since 2022 with past medical history of unspecified dementia, essential primary hypertension, underweight, muscle wasting, restlessness, and agitation, etc.

MDS dated 5/22/2023 section G coded R4 as requiring extensive assistance with one-person physical assist for ADLS, section H stated that resident is always incontinent of bowel and bladder.

Fall care plan initiated 9/27/2022 stated that R4 is at risk for falls related to having cognitive deficit, incontinence, muscle weakness, poor balance, poor safety awareness, etc. Interventions include assist resident to get up and out of bed when resident is not feeling sleepy, rounding of every two hours and prompt or assist for change in position, toileting, promote placement of call light within reach etc.

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R4 had an unwitnessed fall on 7/15/2023, sustained a laceration to her forehead, was sent to the hospital and returned to the facility with sutures to her forehead. R4 also had unwitnessed falls on 7/29/2023, 8/27/2023, and 10/1/2023.

On 11/4/2023 at 2:04PM, V44 said that residents who are assessed as needing supervision could be more of cueing, not hands on, and depends on residents. Those who are assessed with weakness or lack of coordination should be monitored frequently, those in the memory care unit should be always monitored all day long.

R16 is a 72-year-old female with a diagnoses history of Partial Paralysis, Cerebrovascular Disease, Contracture of Muscle Right Upper Arm, COPD, and Schizophrenia who was admitted to the facility 07/25/2019.

On 10/30/2023 at 12:46 PM R16 stated V35 (Certified Nursing Assistant) pushed her right hand into the left bed rail when turning her over and injured her hand.

R16's Minimum Data Set Assessment dated 08/17/2023 documents she requires extensive one person assistance with bed mobility and totally dependent on two-person assistance for transfers.

R16's current care plan initiated 11/20/2012 documents she is noted to resist care with interventions including Accept residents right to refuse and show respect for residents decision.

R16's progress notes dated 09/03/2023 at 12:21 PM documents she reported to nursing staff that she was abused by a CNA (Certified Nursing Assistant); at 12:50 PM V28 (Licensed Practical

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S9999	Continued From page 16 Nurse) documented she was made aware that R16 was bleeding from her right hand, her right hand fifth finger area was bleeding, pressure was applied to stop the bleeding and area cleaned and wrapped with gauze. Final Incident Investigation Report submitted to the state agency 09/07/2023 documents R16 made an allegation against V35 (Certified Nursing Assistant) concerning delivery of care; The incident occurred in R16's room and V35 was immediately sent home; Her roommates are alert and oriented and did not witness any abuse against R16, other residents interviewed expressed no concerns regarding the care rendered; R16 has given various reports in the past of her hand being broken years ago by her husband and her hand being broken from her bed when she was younger: R16 denies feeling intimidated by staff and has a history of hallucinations, delusions, erratic behavior, and bizarre thoughts. Resident Services Screening Tool dated 09/07/2023 documents R16 reported her husband broke her hand and it had been broken for years, she broke her hand when she was a little girl, and she told them her CNA broke her hand too. Undated statement included in Final Incident Investigation Report submitted to the state agency 09/07/2023 from V28 (Licensed Practical Nurse) documents a CNA (Certified Nursing Assistant) came to her and reported R16 was upset with her while performing activities of daily living care and she hit her, V28 went to R16's room and R16 stated "she pushed me so hard, she hit me and broke my finger, she threw my pop away, right finger observed bleeding, area	S9999		

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S9999	Continued From page 17 cleaned and bandage applied. Investigation statement from V29 (Scheduler) dated 09/03/2023 documents V28 (Licensed Practical Nurse) notified me that R16 informed her that a CNA broke her finger and pushed her. Investigation statement included in Final Incident Investigation Report submitted to the state agency 09/07/2023 from R33 (Resident) documents she reported she saw a CNA shove R16. Investigation statement dated 09/03/2023 from V35 (Certified Nursing Assistant) documents when providing activities of daily living care to R16 she became upset and became physical with staff, during this incident R16 tore her skin in between her fingers with her long nails; V35 informed the nurse and was advised by the nurse that whenever R16 denies care to leave her. R16's undated investigation statement on allegation included of abuse included in Final Incident Investigation Report submitted to the state agency 09/07/2023 documents a Certified Nursing Assistant jumped on her while she was taking care of her; her jaws and fingers are hurting; the person's name is V35 (Certified Nursing Assistant) pronounced in a different manner. On 11/01/2023 from 12:16 PM - 2:10 PM V1 (Administrator) stated she believes she received two allegations involving resident care for V35 (Certified Nursing Assistant). V1 stated one resident reported he didn't like the way V35 was providing feeding assistance and she received another report from R16 with an allegation that V35 broke her hand. V1 stated CNA's (Certified	S9999		

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S9999	Continued From page 18 Nursing Assistants) are informed if a resident becomes combative or resists care you should back off and request assistance because that's how reportable incidents occur. V1 stated it is plausible if R16 has long fingernails that her hands were caught down in the railings and possibly became wedged during the alleged incident and could have injured her finger that way. V1 stated R16's injury during the incident was a fresh wound on her hand. V6 (Assistant Director of Nursing) stated in the process of being repositioned or turned over it's possible for R16's hand to become wedged in between the mattress and bed rail. V6 agreed it can't be determined if this did or did not occur during the alleged incident. V6 stated the fact that V35 reported that R16's hand was injured while activities of daily living care was being provided is why she came to the conclusion that it's possible that R16's hand became injured in the process of receiving care in the manner in which it was described. R17 is an 81-year-old female with a diagnoses history of Stage 3 Chronic Kidney Disease, Dementia, and Other Specified Depression Episodes who was admitted to the facility 06/30/2022. R17's Quarterly Minimum Data Set dated 01/05/2023 documents she requires one-person physical assistance and supervision for walking in room, corridor, and ambulating on and off the unit. R17's current care plan documents she is at risk for falls due to Cognitive Deficits, Diagnoses and/or Disorders, Incontinence, Dementia, use of anti-hypertensive and psychotropic medication with interventions including assure resident is	S9999		

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S9999	Continued From page 19 wearing eyeglasses; ensure that R17 takes brakes with ambulating and has somewhere to sit near the nurses station when she is there; Monitor for changes in ability to navigate the environment. R17's current fall care plan does not include supervision while ambulating. R17's incident report dated 03/12/2023 documents he was observed sitting in her room on the floor, when asked why she stated she just wanted to sit down, upon assessment it was noted she had swelling on right side of her forehead. R17 was assessed, bed remained in lowest position. Injury included swelling of forehead. R17's progress notes dated 3/12/2023 07:10AM Post Occurrence Documentation states she was noted setting in her room on the floor, when asked why she was sitting on the floor she stated that she just wanted to sit down, upon assessment it was noted that she had swelling noted on the right side of her forehead. R17's progress notes dated 3/13/2023 at 08:30 AM documents writer called PPHP (Provider Partner's Health Plan) hotline to report new findings from the follow-up on the resident whose right eye is now black and swollen; at 10:36PM writer assessed the resident and observed swollen on the right orbital region (right eye), vitals are stable nurse practitioner notified, ice packed was placed on the affected part, Resident complained of slight pain during shift writer continue to placed Ice pack on patient affected part. On 11/01/2023 from 12:16 PM - 2:10 PM V1 (Administrator) stated R17's black eye was due to	S9999		

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S9999	Continued From page 20 a fall. V1 stated there was no root cause analysis completed for her fall in March, and she doesn't want to guess as to how she fell. V6 (Assistant Director of Nursing) stated R17 has an unsteady gate but isn't sure if this was her status in March. V6 stated R17 ambulates on her own, is very combative at times and walks all day on the unit. V1 stated R17 had a fall in 01/17/23 and 03/12/23. V1 stated a root cause analysis should be done when a resident has a fall which would be documented under a risk management report and it there isn't one for her fall in March. V1 stated whatever is determined from a root cause analysis would be added to the care plan. V6 stated in January R17 fell in front of a nurses station after standing for a long period of time. V6 stated the results of the root cause analysis from that was impaired cognition and balance. V6 stated R17's incident report from March does not document where she was located but the black eye she sustained could have been from hitting her bedside table or dresser during the fall. V6 stated R17 doesn't need consistent supervision however, she refuses care daily and needs consistent redirection throughout the day. V6 stated one person staff supervision means having a staff member present with a resident to observe them directly when they are moving. V6 stated this means staff should have their eyes directly on R17 when she is self-ambulating. V6 stated R17's status of requiring one person staff assistance and supervision according to her quarterly minimum data set assessment from January means someone being present to observe her may have preventedher from falling in March. V1 stated R17 has a BIMS (Basic Interview for Mental Status) of 15 means she was able to pull her call light and if she pulled the call light when she had her fall in March someone could have assisted her. V6 stated R17 does not use her call	S9999		

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S9999	Continued From page 21 light. V1 and V6 stated they are not sure if R17 was using her call light to request assistance in March. V1 stated she believes R17's fall was unavoidable because she has the cognition to be able to pull her call light. V1 agreed they would not be expecting her to use her call light for assistance based on her current behavior of not using it. The facility's Fall Management Policy reviewed 11/02/2023 states: The facility is committed to minimizing resident falls or injury so as to maximize each resident's physical, mental and psychosocial well-being. While preventing all resident falls is not possible, it is the facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventive strategies and facilitate a safe environment. "Plan of care reviewed and updated at time of occurrence, quarterly, and as needed in order to minimize risk for fall incidents." (B)	S9999		