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
	IL6008635	A. BUILDING: ______ B. WING ______	C 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL OF SKOKIE, THE	9615 NORTH KNOX AVENUE SKOKIE, IL 60076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint investigation. 2491975/IL170756 2492091/IL170894	S 000		
S9999	Final Observations Statement of Licensure Violations: One of Two: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)2)3)8) 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	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/22/24

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a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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

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

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nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and

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restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out.

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to have effective system in place to prevent a resident from leaving the facility unauthorized on two different occasions. This affected one of three residents (R1) reviewed for supervision and elopement. This failure resulted in R1 being buzzed out of the facility with a visitor without staff knowledge on 01/05/24, and R1 able to leave the facility without staff knowledge on 03/11/24 after a staff member failed to ensure the door was closed securely after entering.

Findings include:

R1 face sheet shows diagnosis of unspecified dementia, severe with other behavioral disturbance. R1 MDS (Minimum Data Set) dated 2/21/24 denotes in part section "C" for cognitive patterns a BIMS (Brief Interview Mental Status) of 2 (cognitively impaired).

Police report dated January 5, 2024, denotes in part on 05 January 24 at approximately 2:11pm hours, I (officer) was dispatched to the (street name) intersection for a public fall on the northeast corner. Upon arrival, I spoke with (fire department) who stated a passing motorist (V2- concern citizen), noticed an elderly male, later identified as R1, walking eastbound on the north sidewalk. V2 stated the male was walking with an unsteady and unbalanced walk and stated he

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continued to watch the male because he thought R1 was going to fall. V2 stated as R1 turned to go north on the sidewalk, he lost his balance and fell onto the grass parkway. V2 stated he could not tell if R1 lost his footing and fell or if he tripped over the sidewalk. V2 stopped his car and checked on R1. I contacted (police department) Communications and advised them to send an Evidence Technician. E.T. (Officer) arrived on location and photographed the scene and R1. See his report for further. Transported R1 to (local) Hospital for treatment as they could not determine who the male was or his injuries. The elderly male could not provide a name or if he was uninjured. Once at Hospital, he was seen by the emergency room staff and (physician name). I was unable to speak with R1 as he only spoke Spanish. R1 stated to the Emergency Room nurses, that he was not injured and was transported to the emergency room by the ambulance. While I (officer) was on scene at (the location of the fall), employees from the (nursing facility), stopped and asked if we had seen one of their residents, but did not provide a description. I advised them the ambulance took an elderly male to the hospital, but the male would not provide a name. It was later determined R1 was a walk away from the (nursing facility). The (nursing facility) was contacted, and they arrived to pick up R1. The employees from the (nursing facility) requested R1 be checked out by the hospital staff.

Police report dated 3/11/24 denotes in part, on 11 March 2024, at 8:24 hours, I (Officer) was dispatched to the north entrance area of (store name) on (street name) for a report of a public fall. (Local police department) Communications received a call from V15 (concern citizen), stating she was with an elderly male who seems

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S9999	Continued From page 5 disoriented and appeared to have fallen. Upon arrival, I briefly spoke with V15 who advised she was driving (west bound) on (street name) when she observed an elderly male with a walker on the parkway area of the sidewalk. She pulled into the (store name) lot and assisted the elderly male up and called (local police department). The area was the grass between the sidewalk and (street name). The elderly male was identified as (R1 name). R1 was unable to explain where he had fallen. (R1) did not have any visible injuries on his person. (R1) was wearing a fleece jacket which the right elbow part of the jacket appeared to have grass debris. R1 was unable to answer (local fire departments) questions and was transported to (local) Hospital. The parkway area of the sidewalk had no objects that may have caused R1 to fall. R1 was walking with a walker and appears to have trouble walking due to his medical illness/age. R1 had no visible injuries. (R1) did not have any identification on his person and (local fire department) recognized R1 due to a previous public fall, RD #24-00110. Per the report, (R1) was a patient at (local) nursing (facility), (facility address). I went to (nursing facility) and spoke with the front desk receptionist who advised R1 was a patient. She briefly spoke with the nurse in charge who advised they did not know that (R1) had left the property. I advised staff that R1 had fallen and was taken to (local) Hospital. I spoke with Director of Nursing, (V10) (number listed) who was advised of the incident and stated he was going to review camera footage to see how R1 was able to leave the property. I went to (local) Hospital Emergency Room #1 and spoke with R1 in Spanish. (R1) stated the following: (R1) was going for a walk and advised he has trouble walking. He did not want to walk on the sidewalk as it was dirty, so he began to walk on the grass. R1 lost his balance	S9999		

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as he was walking on the grass with his walker and fell. (R1) advised he was walking on (street name) and advised they just repaved the road, so he was unfamiliar with the street. I advised (R1) he was not on (street name) and not in Chicago. I spoke with R1's daughter/emergency contact, (V1- R1 family) via (telephone) (number listed). V1 stated the following: I advised V1 of the incident and the status of R1. V1 advised R1 has dementia and should not be walking alone. V1 was frustrated that the nursing staff did not notice R1 had left the property. V1 advised R1 has left the nursing home unsupervised approximately three (3) different times. R1 advised she was on her way to Hospital. I provided (nursing facility) and V1 with a incident referral card.

On 3/12/24 at 3:24pm V1 (R1 family) said she was R1 power of attorney, V1 said R1 has dementia and uses a walker for ambulation. V1 said R1 should not be out of the facility alone and unsupervised. V1 said she did not give permission for R1 to leave the facility on 1/5/24 and 3/11/24. V1 said the police notified her that R1 was found on 3/11/24 and she rushed to the hospital to see R1. V1 said R1 left the facility a total of 2 times. V1 said R1 does not wear a wander guard band.

On 3/14/24 at 10:29am R1 observed resting in bed, awake, alert, orient to name, R1 observed to speak Spanish language. V4 (Registered Nurse) assisted with translation, R1 said he left the facility, R1 said he did hear the door alarms. R1 said no one was at the front desk. R1 complain of pain in his back. R1 laid in the bed to get some rest.

Facility incident report labeled unwitnessed fall, dated 1/5/24 at 3:11pm am denotes in part, R1

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name, incident location outside. Resident was observed kneeling on the ground. Thorough physical assessment done, no injury, denied hitting head, full range of motion to all extremities. Resident unable to give description. Head to toe and pain assessment done, denied pain complaints, 911 was called. Resident taken to (hospital emergency room) for further medical evaluation. Taken to hospital "Y". Mental status orientated to person.

Facility incident report labeled other, dated 3/11/24 at 8:25am denotes in part, R1 name, incident location out of facility, Resident went out to walk outside and was picked up by the (local) police officer (name noted) Resident was taken to (local) hospital for evaluation. Resident description" I was just walking". Immediate action, taken to ER (emergency room). DON (Director of nursing) and administrator went to see resident right away. He was resting well in bed. He denied pain, no objective signs of pain or discomfort, no facial grimacing, moaning, etc. taken to hospital "Y". Mental status, orientated to person, orientated to place. Agency /person notified family member and nurse practitioner.

On 3/14/24 at 11:43am V10 (Director of nursing) said R1 did not elope from the facility on 3/11/24 and that R1 went for a walk. V10 said R1 did not inform any staff at the facility that he was going for a walk, V10 said the staff did not know R1 was going for a walk, V10 said R1 did not have an order to leave the facility unsupervised and go for a walk. V10 said he do not know where R1 was going walk to. V10 said he do not know if R1 is at risk for elopement and he will get back to the surveyor. On 3/15/24 at 1:47pm during a follow up interview, V10 said R1 was at risk for

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S9999	Continued From page 8 elopement. V10 said R1 eloped from the facility twice. V10 said on 1/5/24 he received notification from a staff member that the neighboring facility notified them (male staff member) that the fire department had picked a male up from the ground. V10 said himself and a staff member went to the scene and the police informed them that the male was sent to the hospital. V10 said himself and the staff member went to the hospital and identified that R1 was the resident that the fire department had picked up from the ground. V10 said on 1/5/24 the receptionist pressed the button to allow visitor to leave the facility and R1 left the facility behind the visitors. V10 said the receptionist was not at the front desk monitoring the entry door but instead was sitting behind the nurse's station on the first floor when she pressed the button. V10 said she pressed the button and sat back down; she did not look to see who was leaving the facility. V10 said the receptionist did not see R3 leave behind the visitors. V10 said the receptionist should be at the front desk/ front lobby monitoring that area and door. V10 said the interventions was to monitor R1. V10 said on 3/11/24 R1 left the facility after V3 (CNA- Certified Nursing Assistant) entered the facility. V10 said the door has a delay before it locks. V10 said he watched the video. V10 was asked why didn't V3 redirect R1 front the front lobby area as mentioned in the care plan. V10 said V3 was a newer CNA, and she did not know R1 well, she did not know R1 was an elopement risk. V10 said R1 daughter did contact him on 3/11/24 and express her concerns of R1 leaving the facility unsupervised, V10 said R1 daughter said, "what if my father had been hit by a car". V10 did not give response when asked if the monitoring was effective if R1 was able to leave the facility on 3/11/24.	S9999		

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Observation of the Nurse station, there is a green square button located on the wall behind the nurse station. V26 (CNA) observed to press this button when door alarm sound. V26 (nursing aide) said this button is used to unlock the front door and to shut the door alarm off.

On 3/14/24 at 1:41pm V3 (CNA-Certified Nursing assistant) said on 3/11/24 she came inside the facility, she saw R1 in the front lobby, R1 had his jacket on and R1 had his walker, R1 was standing between the door and the front desk (V3 drew a picture demonstrating R1 position). V3 said she greeted R1 and went downstairs to punch in for the day. V3 did not respond when asked if she was aware that R1 was an elopement risk. V3 denied redirecting R1 from the front lobby area when she observed him with his jacket on. V3 said there were no staff in the front lobby on 3/11/24. V3 did not give response when asked about her understanding of elopement risk, and how do she know who are the residents that are at risk for elopement.

Review of V3 timecard denotes V3 punched in at 8:09am on 3/11/24.

On 3/15/24 at 10:09am, V7 (social worker) said R1 is at risk for elopement. V7 said R1 cannot go out of the facility without supervision. V7 said R1 has dementia, poor safety awareness, unsteady gait, and is at risk for falls. V7 said R1 cannot go out without supervision for safety reason. V7 said due to R1 dementia, R1 may not know how to return to the facility, R1 may not know how to contact his family and or the facility, R1 may not be able to cross the street safely. V7 said R1 eloped from the facility on January 5, 2024, and recently on 3/11/24. R1 elopement risk assessment dated 2/21/24 reviewed with V7. V7

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said she completed R1 elopement risk assessments and may have documented in error that R1 did not have history of elopement. V7 said she checked "No" for is the resident considered to be at risk and "no" for elopement risk because R1 behavior had slowed down from going to the front lobby area. V7 said the elopement risk assessment helps with identifying residents that are at risk for elopement. V7 said the information is used to develop a care plan and interventions to prevent elopement. V7 said R1 elopement risk assessment is not accurate, it does not reflect that R1 is at risk for elopement. V7 said R1 assessment should be answered accurately, so that interventions can be put in place to help prevent R1 from getting out of the facility. V7 said she has observed R1 with exit seeking behaviors like standing around the door, looking around to see if people are going to leave out. V7 said sometimes she monitor the front door, and she have observed R1 with exit seeking behaviors.

On 3/14/24 at 11:43am V12 (Administrator) said the facility video camera was not available for surveyor to review. During a follow up interview, on 3/15/24 at 11:14am V12 (Administrator) said he reviewed the facility video and observed R1 leave the facility with his walker on 3/11/24 after V3 entered the facility. V12 said the police notified the facility that R1 was found in the community. V12 said the department was not notified of R1 elopement on 1/5/24 or the elopement on 3/11/24. V12 said he thought the police would report the elopement to the state agency. V12 said the police do not work for the facility. V12 said he should have reported R1 elopement to the State agency (IDPH).

On 3/14/24 at 10:32am V13 (Receptionist) said she was running late on 3/11/24, and she was not

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in the facility monitoring the front desk. V13 said the residents that are at risk for elopement have pictures in the computer, V13 said everyone that monitor the front desk don't have a login for the computer. V13 was asked how the staff will know who are at risk for elopement if they don't have access to the pictures in the computer. V13 said she's trying to start a folder for the pictures.

On 3/21/24 at 11:11am V24 (Medical Doctor) said the facility made him aware that R1 left the facility, V24 was made aware of survey findings that on January 5, 2024, a staff member buzzed out a visitor and R1 left behind the visitor and on 3/11/24 R1 left the facility after a staff member entered the facility before the door locked per facility. V24 said he was not there, maybe staff wasn't paying attention. V24 said it's an unfortunate situation. V24 said the facility mention something about a wander guard, he's not sure. V24 said the elopement could have been avoided.

On 3/21/24 at 12:16pm V22 (Nurse Practitioner) said R1 is on her caseload, V22 said she sees R1 for routine visits, V22 said she was not aware of R1 elopement on 1/5/24, the facility did not make her aware, V22 was made aware of survey findings related to R1 elopement on January 5, 2024. V22 and the facility made her aware of the 3/11/24 elopement on 3/14/24. V22 said the facility told her that a staff member heard the alarm sounding, or something. V22 said she was not aware that the police found R1 in the community and notified the facility that R1 was out of the facility. V22 said the facility should have made her aware of both elopements. V22 said she request R1 to have a wander guard bracelet. V22 said she did not see anything in R1 notes about the elopements.

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R1 community survival assessment dated 2/21/24 denotes in-part, the resident is sufficiently alert, oriented, coherent, and knowledgeable allowing him/her to be considered for independent outside pass privileges, "No" is checked. Conclusion, the resident does not appear to be capable of unsupervised outside pass privileges at this time. The resident cannot have unsupervised outside pass privileges, at this time. Signed by V7 (social services).

R1 elopement risk assessment dated 2/21/24 denotes in-part, R1 name, score "3", is the resident cognitively impaired with impaired decision-making skill, "yes" is checked. Does the resident have diagnosis /symptoms of any of the following: dementia, Alzheimer's, "yes" is checked. Does resident ambulate independently with or without assistive devices including wheelchair, "yes is checked". Does the resident have a history of elopement from home or facility, "no" is checked. Is the resident having difficulty accepting placement, "no" is checked. Does the resident verbally express a desire to go home, "no" is checked. Does the resident pace expressing a desire to locate a family member, "no" is checked. Has the resident been observed standing at the exit door waiting for someone to let them out, or verbalized a plan to exit, "no" is checked. Total score (a score of 5 or more is considered to be at risk for elopement). Is resident considered to be at risk, "no" is checked. Elopement risk, 4 is checked for not at risk. Observation of the first-floor nurses' station, the nurse's station has a high countertop, when sitting behind the nurse's station, the person must come to a standing position to see who is exiting the front door, which is greater than 15 feet away.

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R1 plan of care with initiated date of 3/11/24 denotes in part resident (R1) is high risk for wandering/elopement identified, resident safety will be maintained will not leave facility unattended through next review. Close monitoring of residents whereabouts at least hourly. Provide resident picture at reception desk and at nurse station. Engage resident on all floor activities to redirect/divert attention to deescalate elopement ideas. Encourage family visits as often as needed. Involve family to help redirect resident in a meaningful conversation to mitigate unsafe notion to leave unattended. Ensure doors are secured alarmed.

R1 plan of care for cognitive loss dated 5/3/2023 revised on 3/11/24 denotes in part, I (R1) am an older adult functioning with dementia. I may respond coherently at times, other times I may display cognitive challenges. My concentration and attention-span may be affected. I have reduced cognitive processing speed and deficits in executive functions such as abstract reasoning, planning, problem solving, impaired conversational skills, and lack of initiation. My strengths include my enjoyment of physical movement, exercise (including walking) and keeping busy. I have periods of lucidity and greater awareness. I will accept interventions to avoid complications/decline concerning my cognitive loss and I will be provided care/activities/interventions to help strengthen and promote my cognitive skills. Emphasize keeping R1 busy and engaged. Review his favorite and preferred activities which often include movement, exercise, physical tasks; solicit additional ideas for engagement from his family. Offer opportunities to 'move with music.' Cue, reorient and supervise as needed.

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R1 plan of care for falls denotes in part, R1 is at risk for falls r/t (related /to) gait/balance problems, poor communication/comprehension, unaware of safety needs.

Facility policy titled "Wandering, Unsafe Resident" revised dated of 8/2014 denotes in part the facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement). The staff will assess at risk individual for potentially correctable risk factors related to unsafe wandering. The resident care plan will indicate the residents is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as detailed monitoring plan will be included.

Facility policy titled Care plans, comprehensive person centered with revised date of 12/2016 denotes in part a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Incorporate identified problem areas, incorporate risk factors associated with identified problems.

(B)

Two of Two:

300.610a)
300.1010h)
300.1210b)
300.1210d)2)3)6)

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Section 300.610 Resident Care Policies

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

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B)

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

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

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

2) All treatments and procedures shall be administered as ordered by the physician.

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

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to follow the order of the primary care provider by not ordering a STAT Xray after a fall incident. This affected one of three residents (R4) reviewed for following the physician orders. This failure resulted in a 13-hour delay in R4 having an Xray conducted subsequently resulting in a diagnosis of 5 right side rib fractures and an acute fracture of right elbow.

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Findings include:

R4 care plan shows diagnosis of intervertebral disc degeneration lumbar region, bipolar disorder, history of falling, pain in the right elbow, repeated falls, fracture of one rib left side, multiple fracture of ribs right side an issue for close fracture, multiple fracture of ribs left side initial encounter for closed fracture, displaced fracture of right radius encounter for closed fracture with routine healing, presence of orthopedic , difficulty walking, need for assistance with personal care.

On 3/29/24 R4 observed alert and orient to person, place, time.

Facility incident report titled witnessed fall, dated 1/18/24 at 6:45pm, R4 name noted, location: front lobby, person preparing report V16 (Nurse). Resident demand to stay at the porch for a few minutes to get some fresh air writer instructed resident that due to weather condition it would be better if he can wait until tomorrow when the weather gets better. Resident demand and yell at the nurse stating that he is not a prisoner and all he needs to get just 5 minutes to get some fresh air. Resident wore jacket and with appropriate shoes. Nurse assisted resident on his way out to the porch when he lost his balance and fell on his bottom with his right hand on the floor in attempt to abort the fall at the main entrance. Head to toe assessment done able to move all extremities without difficulty. Resident was instructed to stay put until staff can get the wheelchair, but he stood up immediately saying that he is fine. Resident did not hit his head. Vital signs 121/68, pulse 72, R18, temp 97.5. Resident stated that he lost his balance and fell on his bottom. Hand to toe assessment done. Vital signs taken DON, PCP (primary care provider) and are all informed. R4

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sister. Injuries observed at time of incident right hand palm and other location. Pain level 6 alert ambulatory without assistance. Mental status alert to person orientated to situation, orientated to place, orientated to time, PEARLA (pupils, equal, round, reactive light accommodation). Predisposing physiological factors history of falls, other impulsive behavior. Witnesses; V16. Agencies notified DON (Director of nursing), physician and family member. Notes 1/19/24 per investigation resident fall is because he was trying to get into the door with the nurse behind him and as he opened the door lost balance and fell. Resident is always in a rush doing things in he's very impulsive.

R4 progress notes date 1/18/24 at 9:02pm denotes in-part V24 (physician) gave an order of Xray of right elbow and right rib as per resident complain of pain on his body parts. Xray was ordered to (radiology provider) (name noted).

R4 physician progress notes dated 1/19/24 at 10:30am denotes in-part, CC (chief complaint), s/p (status/post) fall, pain management, anxiety, HTN (hypertension), old rib fracture. Seen an examine per patients request. The resident approached the writer in the hallway and reported that he had a fall on 1/18. According to the patient he wanted to go outside to the porch that day to get some fresh air he was rushing lost his balance then fell and landed on his "butt". PCP (primary care physician) was notified per record and ordered STAT X-ray of right elbow pending result. Today patient c/o (complain of) (R) right-side pain. Stat CXR (chest X-ray) order pending results. Informed NOD (nurse on duty) to administer pain medications and re-counsel resident on fall precaution.

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S9999	Continued From page 19 R4 progress notes dated 1/19/24 at 1:34pm denotes in-part receive resident in his room post fall monitoring, check vitals within normal limits. Complaining of right elbow and right rib pain, given Norco as ordered. X-ray already ordered; NP (Nurse Practitioner) seen the resident. New order for chest X-ray, order carry out. Called (radiology provider) and confirmed the order. Resident is resting in his bed now, comfortable, all needs attended. Call light within reach continue to monitor. R4 progress notes dated 1/20/24 at 12:08am denotes in-part receive resident in bed complaining of severe pain to right rib and right elbow related to recent fall. Medicated for pain and effective X-ray order and done. Result of X-ray receive at 7:30 PM. Resident has fractured to right rib and right elbow. (Doctor) notified and order to send resident to the hospital resident his sister Don were informed nurse call ambulance and will arrive in 45 to 90 minutes but later on (ambulance company name) called and the ambulance will be late for 2 hours. Nurse canceled and called 911. DON agreed. Resident picked up by 911 at 11:55pm. R4 emergency room records dated 1/20/24, arrival time 12:04am, 68-year-old male presents with right rib and right elbow pain for 1 day. CT chest 1/20/24 acute nondisplaced right rib fractures are noted including the right lateral sixth, right posterior lateral seventh, right posterior lateral 8th right posterior lateral 9th and right posterior lateral 10th rib. Xray right elbow there is an acute fracture nondisplaced fracture of the radial neck, trace right hemothorax. R4 emergency room triage note denotes in-part patient arriving via (local) Emergency Medical Services, patient is from (nursing facility), patient	S9999		

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is alert and orient X3, c/o right elbow and right rib pain. RN (Registered Nurse) at (nursing facility), states patient had a witnessed, mechanical fall yesterday, and landed on right elbow and right rib. Patient X-rays done, fracture of right elbow, and right rib, so sent to ER (emergency room). Patient work of breathing, SPO2 (oxygen), RR (respiratory rate) WNL (within normal limits). A/P (assessment/plan) R4 is 68 year old male with past medical history of HTN, HLD, hypothyroidism, schizoaffective disorder who lives at citadel now admitted after sustaining a fall to right side and has nondisplaced R (right) 6/10 rib fracture and L (left) min displaced 7-9 ribs. Pain poorly controlled and limiting mobility. Breathing well on room air. Chest well moderate. Transferred to highland park hospital for further management.

R4 radiology results report dated 1/19/24 at 5:48pm completed by (portable Xray company name) denotes right elbow 2 views, impression: suspected acute radial head fracture with associated small effusion hardware fixation of the proximal ulna is anatomic. Right ribs 2 views, impression: acute right-side fracture of the 7th and 8th posterolateral ribs.

On 3/29/24 at 4:51pm V24 (Physician) said whenever there's a fall and the resident complain of pain the facility should order a STAT Xray. V24 said he don't recall all the details of R4 fall, but he does remember the facility mentioning something about R4 falling and the was a fracture to the left rib.

On 3/29/24 at 11:26am V16 (RN-registered Nurse) said she was R4 nurse on 1/18/24. V16 said R4 wanted to go outside to get some fresh air, V16 said she was telling R4 that it was cold,

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V16 said R4 wanted to go any, V4 said she was walking behind R4 because R4 is fall risk. V16 said R4 fell in the foyer when R4 lost his balance, V16 said there was a visitor coming inside when R4 was going out of the building. V16 said the visitor gave way to R4 (the visitor allowed R4 to pass). V16 said R4 fell, R4 did hit his right side slightly on the radiator, and landing on his buttock. V16 said she don't recall who the visitor was, V16 said the visitor did not body slam R4, the visitor did not touch R4, V16 said the visitor gave way to R4. V16 said R4 fell when he lost his balance. V16 said she don't know why she did not document that R4 hit his right side on the radiator when he fell. V16 said R4 did complain of pain in his hand. V16 said after the fall R4 stood up, but she got R4 a wheelchair. V16 said she assessed R4 for injuries and R4 complained that his hand hurt. V16 said she did give R4 pain medication, she notified the doctor and R4 family. On 4/2/24 at 9:22am V16 said V20 (physician) gave orders for R4 to have an Xray, V16 said she don't recall if the orders were for STAT Xray. V16 said she did not call the physician back to clarify if he would like a STAT Xray when R4 observed with complaints of pain to the right-side rib pain.

Review of R4 physician order sheet there were no Xray orders noted in the electronic records dated for 1/18/2024.

On 4/2/24 V10 (Director of Nursing) said the facility nurses know what to do if there's a delay in a STAT Xray. V10 said when the nurse receives an order for a routine Xray, from the physician or Nurse practitioner the Nurse should input the orders in the electronic records within 2 hours of receiving the order and if the order is for a STAT Xray the nurse should put the order in the electronic system right away. V10 explains the

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S9999	Continued From page 22 Xray orders go directly to the radiology company for review. V10 said R4 received medication for the right-side rib pain at the facility. V10 said he was aware that R4 was diagnosed with five right-side rib fractures and an acute fracture to the right elbow at the hospital. V10 said if the resident pain level is under "8" he expects a routine Xray to be completed, V10 said if the resident pain level is "8" or higher he expects a STAT Xray to be completed. V10 said ordering a STAT vs routine Xray also depends on the physician. On 4/2/24 at 9:22am V25 (XRAY COMPANY Rep) said the company received a Xray order for R4 on 1/19/24 at 10:24am as a routine order, V25 said R4 routine Xray exam was upgraded to STAT at 5:19pm on 1/19/24 and the company was onsite to complete the Xray for R4 at 5:20pm. V25 explained that a STAT Xray will be completed with results within 4-5 hours and a routine Xray will be completed with results within 24 hours. V25 said he does not have any Xray orders for R4 for 1/18/24. V25 said the company notice that the exam times have been showing as 12:00 midnight, V25 said R4 Xray was not complete at 12:00 midnight as shown on the report. Review of R4 order audit denotes in-part date 1/19/24 at 10:23am, chest two views. On 1/19/24 at 5:07pm right ribs, unilateral, (with) posteroanterior chest, 3+ views. R4 pain evaluation dated 1/18/24 at 6:46pm completed by V16 denotes in-part resident is able to understand and be understood regarding their pain, pain score 5, location right elbow and right iliac crest, characteristics of current pain: intermittent pattern.	S9999		

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Facility policy titled "Physician Orders" with revised date of February 2019 denotes in-part all orders including medications and treatments labs and ancillary orders must be ordered by a licensed physician or nurse practitioner. All orders will be consistent with principles of safe and effective writing order. All orders will be processed and carried out by nursing service personnel as soon as the order has been received. The nursing staff member who took the order or the one assigned to the resident is responsible to transcribe the order. Transcribing orders include writing new orders on the medication administration record or treatment administration record or completing laboratory test request dietary notification form or ancillary notification to inform others of the change in order as necessary for facilities in EHR (electronic health records) orders must be properly entered into the computer and attached to appropriate flow sheets IE medication treatment or lab flow sheet.

Facility Radiology contract with agreement date denotes in-part duties and obligations of facility will promptly schedule the patient service per the providers ordering procedure provider will in service facility on ordering procedure.

On 4/2/24 at 8:41am V12 (administrator) presents the radiology contract for (radiology provider), stating he alternates between companies.

(A)