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
	IL6001614	A. BUILDING: ______ B. WING ______	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESIDE HOUSE OF CENTRALIA	1030 MARTIN LUTHER KING BLVD CENTRALIA, IL 62801

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S 000	Initial Comments Annual Licensure survey. Investigation of Facility Reported Incident of November 29, 2023/IL169252 Investigation of Facility Reported Incident of January 16, 2024/IL169249	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)4)5) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE 03/21/24

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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.

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

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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:

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.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review the facility failed to keep a resident's environment free of accident hazards and failed to implement new interventions to reduce falls for 7 of 10 residents (R2, R3, R9, R41, R49, R51, R54) reviewed for falls in a sample of 40. This failure resulted in R2 falling out of bed on 11/29/2023 due to a loose bed enabler and suffering a fractured left acetabular medial wall, a fractured iliopubic junction fracture and a fractured pubic rami.

Findings include:

1. According to R2's face sheet, R2 was admitted on 9/20/2012 with diagnosis of Parkinson's, Muscle Weakness, Muscle wasting and Atrophy, Alzheimer's, Osteoporosis and Convulsions among others. R2's MDS (Minimum Data Set) assessment dated 11/24/2023 documents R2

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S9999	Continued From page 3 needs substantial assistance for dressing, showering and bed mobility. This same MDS documents R2 is dependent on staff for toileting and transferring. R2's MDS dated 11/4/2023 documents R2 was assessed with the BIMS (Brief Interview for Mental Status) in which R2 scored 7 out of 15 indicating R2 has severe cognitive impairment. R2's care plan documents R2 is high risk for falls and planned interventions to prevent falls include anticipate R2's needs, call light within reach, encourage R2 to use call light and staff to promptly respond to R2's call light. This same care plan documents R2 uses bilateral bed enabler bars on her bed for bed mobility and due to seizure disorder. R2's Fall Risk Evaluation, dated 11/29/2023, documented R2 requires the use of assistive devices for gait/balance, has had a change in condition within the past 14 days, is chair bound with incontinence, has had medication changes within the past 5 days, and is a high risk for falls. On 12/3/2023, the state agency was notified of R2 having a fall with serious injury in which R2 fell out of bed on 11/29/23. This Long-Term Care Facility-Serious Injury Incident Report dated 12/3/2023 documented R2 fell out of bed on 11/29/23 at 2:30am due to "loose bed enabler" and was sent to the ER (emergency room) for evaluation of left hip pain. This report documented R2's X-rays were negative at the time of her fall, but R2 continued to have left hip pain and was sent to the ER again on 12/3/23 and CT scan (computed tomography) revealed R2 had fracture of the left medial acetabular wall and admitted to the hospital for treatment. Hospital records for R2 dated 12/3/2023 documented R2 was admitted due to multiple fractures found after falling at the nursing home on 11/29/23. The multiple fractures were	S9999		

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documented as a fractured left acetabular medial wall, iliopubic junction fracture and pubic rami Fracture. The Long Term Care Facility-Serious Injury Report (dated 12/3/2023) documented R2 returned to the nursing home on 12/4/23, was non-weight bearing on her left lower leg and R2's bed enabler was re-secured to her bed for bed mobility.

R2's hospital discharge records dated 12/4/2023 documents the following in part, (R2) who is mostly wheelchair bound presented with hip pain after fall at NH (nursing home). She was found to have multiple fractures. She was evaluated by orthopedics and recommended to be managed conservatively given predominately non ambulatory status. She was discharged back to skilled nursing facility one pain controlled. She was recommended to be non-weight bearing and following up with orthopedics.

On 2/28/2024 at 12:51pm, V11 (Registered Nurse/RN) said she, V9 and V10 (both Certified Nursing Assistants/CNA) were providing care for R2 on 11/29/23 at 2:30am when R2 fell out of bed. V11(RN) said V10 (CNA) yelled for her to come to R2's room where she saw R2 sitting on the floor by her bed. V11 said R2 is very difficult to understand verbally but was able to indicate that she was reaching for her call light and fell out of bed. V11 said one of R2's bed enabler bars were not attached to the bed and was laying on the floor by R2. V11 said R2 had just returned from the hospital on 11/18/2023 and staff removed R2's bed enablers for the ambulance to transfer R2 from her bed to their gurney because the bed enablers are in the way. V11 said she feels R2's bed enabler was not securely re-attached when R2 returned for the hospital on 11/18/2023. V11 said she had no knowledge of

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the facility having a protocol/policy for ensuring resident's bed enablers are re-attached securely after being removed for ambulance transferring purposes.

On 2/29/2024 at 9:00am, V10 (CNA) said she went to answer R2's call light and found R2 sitting on the floor next to her bed. V10 said she did not remember if R2's bed enabler was attached to the bed or on the floor as reported by V11. V10 said R2 had returned from a hospital admission on 11/18/2023 due to seizure disorder. V10 said staff have to remove the bed enablers from the resident's bed when the ambulance comes to get the residents for transfer to the hospital because the enablers are in the way of transferring the resident from the bed to the gurney. V10 said she feels R2's enabler was not securely re-attached when R2 returned from the hospital on 11/18/2023. V10 said she has no knowledge of the facility having a protocol/policy for ensuring resident's bed enablers are reattached securely after being removed for ambulance transferring purposes.

On 2/27/2024 at 12:06pm, V6 (Maintenance) said he applies bed enablers when he is told to do it. V6 said after he attaches the bed enablers, he does not perform any routine checks or maintenance on the enablers. V6 said staff will complete a work order ticket if they notice anything broken or in need of repair about the facility and this included bed enablers. V6 said after R2 fell on 11/29/2023, he re-secured R2's bed enabler, but has not re-checked the bed enabler since that time.

On 2/27/2024 at 12:50pm, V1 (Administrator) said V6 is supposed to do quarterly checks of resident's beds. V1 said R2's bed enabler had

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been rechecked since being re-secured by maintenance, but she could not produce any documentation of them being checked. V1 said she could not produce any documentation of any other resident's bed enablers being checked for looseness since R2 fell on 11/29/2023. On 2/28/2024 at 8:00am, V1 said on the evening of 2/27/2024 she personally checked all residents bed enablers and can ensure all were securely attached.

R2's care plan documents R2 had a fall on 11/29/2023 but did not have any new interventions in place to prevent R2 from having future falls until 2/27/2024 and was added by V8 (Licensed Practical Nurse/LPN Care Plan Coordinator/CPC). R2's care plan documented the intervention of "Enabler re-secured to bed by maintenance staff to assist with bed mobility" initiated on 11/29/2023 but was created on 2/27/2024.

On 2/27/2024 at 10:30am, V8 said no interventions were developed and put into place for R2's fall on 11/29/2023 until the morning of 2/27/2024 when V2 (Director of Nursing) approached her and told her to update R2's care plan with the intervention of re-securing the bed enabler with the initiation date of 11/29/2024.

On 2/28/2024 at 2:30pm, V2 (Director of Nursing/DON) said R2 fell on Wednesday, 11/29/2023, but R2's fall was not investigated until Sunday, 12/3/2023 after R2 was found to have multiple fractures from falling in 11/29/2023. V2 said V17 (RN) is the one who investigates incidents, but she has been on medical leave and no other staff member was assigned to investigate incidences in her absence.

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On 2/28/2024 at 2:19pm, V8 (LPN/CPC) said she does not normally do fall interventions and that is usually done by V17 (RN) but V17 has been out on medical leave.

2. R51's Face Sheet documents R51 was admitted to this facility on 9/3/2021 with diagnosis of Congestive Heart Failure, Chronic Kidney Disease, Dementia, Unsteady on Feet, Muscle Wasting and Muscle Atrophy among others. R51's MDS assessment dated 12/5/2023 documents R2 needs substantial/maximum assistance with toileting, showers, dressing and transferring. This same MDS documents R51 was assessed with the BIMS in which R51 scored a 10 out of 15 total, indicating R51 has moderate cognitive impairment. R51's care plan documents R51 is at risk for falls due to Dementia, Gait and balance problems and incontinence and was initiated on 9/20/2021. R51's Fall Risk Evaluation, dated 12/9/2023 documents R51 is chair bound with incontinence, has problems with balance while standing and walking, has decreased muscular coordination, requires use of assistive devices and is a high fall risk.

A facility incident report dated 1/16/2024 documented at approximately 8:30am R51 had a witnessed fall that resulted in injury. According to the incident report, R51 was walking with V12 (Certified Nursing assistant/CNA) to his recliner, V12 (CNA) let go of R51 to grab R51's wheelchair when R51 lost his balance and fell backwards hitting his head on his dresser causing laceration and was sent to the local ER for evaluation. ER discharge report dated 1/16/2024 documented R51 had a laceration to the back of his head and received 6 staples and returned to the facility.

On 2/26/2024 at 2:00pm, R51 was interviewed

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about his recent fall. R51 said, "I was walking with a girl and fell backwards and hit my head." R51 could not remember much else about the fall.

On 2/26/2024, R51's care plan was reviewed for his fall on 1/16/2024 and no interventions were found in place to prevent R51 from future falls. On 2/27/2024, R51's care plan had been updated by V8 (LPN/CPC) with the intervention of "CNA verbally warned not to turn back on resident when resident is in an upright position."

On 2/27/2024 at 10:30am, V8 said no interventions were developed or put into place after R51 fell on 1/16/2024 and R51's care plan was not updated with a new intervention for falling on 1/16/2024 until 2/27/2024 when V2 (DON) had instructed her to update the care plan.

3. R9's face sheet documents R9 was admitted to this facility on 1/30/2024 with diagnosis of Orthostatic Hypotension, Acute Osteomyelitis of right foot and ankle, Gangrene of right leg with surgical amputation or right toes, Diabetes Mellitus type 2 and Peripheral Vascular Disease among others. R9's MDS dated 2/5/2024 document R9 needs Substantial/Maximum assistance for toileting and dressing and is dependent on staff for transferring. This same MDS documents R9 was assessed with the BIMS and scored 4 out of 15 which indicates R9 has severe cognitive impairment. R9's care plan, with revision date of 2/13/2024, documents R9 is at risk for falls due to gait and balance problems, amputation of right toes and history of falls and R9 had an actual fall on 2/10/2024, however no fall interventions were put into place to prevent future falls according to the care plan. Fall interventions documented on R9's care plan are as follows: Initiated dated on 9/1/2023 anticipate

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resident's needs, assess fall risk and provide appropriate interventions to reduce fall related injuries, assess level of need for ambulation and transfers and assist as necessary, ensure call light and frequently used items are within reach and educate on importance of call light utilization, fall risk assessment upon admission, quarterly and with significant changes, keep room free of clutter, notify doctor as needed and therapy to evaluate as needed.

R9's Fall Risk Assessment, dated 8/28/2023 and done prior to his re-admission date of 1/30/2024, documented R9 is alert and oriented to person, place, and time, has had no falls in the past 3 months, requires the use of assistive devices and is a low fall risk.

R9's incident report, dated 2/10/2024 documented R9 was found sitting on the floor in front of the toilet, Floor was dry. Lights were on. Pants were down. ROM WNL (range of motion were within normal limits) R9 noted with abrasion to left shoulder. No other signs or symptoms of injuries. Assisted up to toilet per 2 staff. Stated (he) was trying to wipe himself and slid to the floor.

On 2/28/2024 at 2:19pm V8 (LPN/CPC) said she could not find any documented interventions developed and put into place to prevent R9 from future falls for R9's fall on 2/10/2024. V8 said she does not usually do the care plans for falls and that V17 (RN) does, but V17 has been out on medical leave.

On 2/28/2024 at 2:23pm, V2 (DON) said V17 (RN) usually does the investigating for incidents, but she has been out for a long time due to medical reasons and no other employee was

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assigned to perform these duties in her absence and the facility definitely needs to revamp how they do things.

4. R54's Face sheet documents diagnosis including: Dementia, History of falling, Muscle wasting and Atrophy, Unspecified lack of Coordination, and Cognitive Communication Deficit. R54's MDS dated 01/02/24 documents a BIMS of 4 indicating severe impairment. Section GG documents: substantial/maximal assistance is needed for transfers.

R54's Care plan with a revision date of 02/08/24 documents: Focus: Risk for falls Dementia: document falls on 10/16/23 and 02/07/24. R54's Care plan does not document any intervention for the fall documented on 10/16/23. R54's Care plan documents a fall on 12/20/22 with an intervention of: Reeducate on importance of call light utilization and waiting for assistance PRN (as needed).

R54's Fall Investigation dated 10/16/23 documents: Immediate action taken: Patient (R54) education to wait for staff for assistance with transfers.

R54's Progress notes dated 10/16/23 at 5:15 PM document: R54 was on floor in an empty room. R54 was assisted back to her wheelchair. R54's wheelchair was unlocked pointing toward bathroom. R54 had shoes on and her clothing dry. R54 stated she was trying to sit in room chair.

R54's Post Fall Evaluation with an Effective date of 02/07/24 at 3:14 PM documents: date of fall: 02/07/24 at 2:33 PM, Fall was not witnessed with the location of the fall as R54's room. Pre-Fall:

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Fall Risk Score: 10. (The facility document titled, Fall Risk Assessment documents a 10 or higher as high risk.) Did injury occur as a result of the fall: yes, bruise to left hand and pain to right hip. Did ER visit/hospitalization occur as a result of the fall: Yes. Has there been a recent change in resident's medications: No. Pain: Indicators of Pain: Vocal complaints of pain - New Issue.

R54's progress notes dated 02/07/24 documents: Fall Details: Date/Time of Fall: 02/07/2024 at 2:33 PM. The fall was not witnessed. R54's fall occurred in the resident's room. R54 was reaching for item(s) at time of the fall. Reason for the fall was evident. Reason for the fall: Messing with stuff in her closet. R54 stated she was trying to get something out of her closet. R54's Fall Risk Score is documented as 10, (The facility document titled, Fall Risk Assessment documents a 10 or higher as high risk.) Did an injury occur as a result of the fall: Yes. Injury details: bruise to left hand and pain to right hip. Did fall result in an ER visit/hospitalization: Yes.

R54's Physician Order Sheet dated 02/01/24 documents an order for Methocarbamol 500 mg with a start date of 02/07/24. R54's X-ray report dated 02/07/24 documents: minimally displaced fractures anterior aspect of right 9th, 10th, and 11th ribs.

R54's Care plan documents an intervention for the fall on 02/07/24 as: Medication changes made.

On 02/28/24 at 1:50 PM when R54 was asked about the fall, she pointed to her rib area, when asked if they hurt, she nodded yes. R54 was verbally unable to be understood.

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On 02/29/24 at 2:00 PM, V2 (Director of Nursing) stated, adding a muscle relaxer would not help prevent with future falls and R54 did not have any other medication changes. V2 stated interventions should not be duplicated.

5. R3's Care plan documents an admission date of 12/22/22 with diagnosis including: Legal Blindness, Dementia, Unspecified Psychosis not due to a substance or known Physiological condition, Restless leg syndrome, Morbid Obesity, History of Falling, Repeated Falls, Unsteadiness on feet, Abnormalities of Gait and Mobility, Muscle Wasting and Atrophy, and Lack of Coordination. R3's MDS dated 01/16/24 documents a BIMS of 8 indicating R3 is moderately impaired. Section GG documents: substantial/maximal assistance is needed for transfers.

R3's Care plan with a revision date of 01/25/24 documents: Risk for Falls Decreased safety awareness, Dementia, incontinence, Vision/hearing problems/ Non-compliant with fall interventions. R3's Care Plan documents R3 has had multiple falls with many interventions.

R3's progress notes dated 01/24/2024 at 10:06 AM Post Fall Evaluation, Fall Details: Fall was witnessed. The fall location: shower room. The activity at the time of fall: R3 was transferring to shower chair without assistance. The reason for the fall was evident. The reason for fall: Transferring without assistance. Did an injury occur as a result of the fall: Yes. Injury details: 1.0 x 0.1 abrasion to left forearm below elbow. Did fall result in an ER visit/hospitalization: No. Fall Details Note: There was a loud noise coming from and shower room and help needed in shower room, R3 was sitting on the floor in

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	IL6001614	A. BUILDING: ______ B. WING ______	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESIDE HOUSE OF CENTRALIA	1030 MARTIN LUTHER KING BLVD CENTRALIA, IL 62801

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shower stall. Contributing Factors: Was fluid spilled on floor: Yes. Clutter present on the floor: Yes. Contributing factors note: R3 was transferring self without assistance. R3 went into shower room for shower was told not to transfer until assistance got in there was another resident showering with staff in the stall next to R3 and R3 transferred herself to shower chair wheels not locked on shower chair and chair moved and resident went down onto the floor on her buttocks hitting her head on shower stall wall. There were no new fall interventions documented in R3's Clinical Records for this fall.

R3's Fall Report dated 11/25/23 documents in part, "CNA yelled for this nurse to come down the hall and assess resident due to her being on the floor. No witness for this fall. This nurse and second nurse went in to evaluate condition and resident was laying on her left side with legs extended. Left arm was underneath resident on the floor ...Resident denies any pain and denies hitting her head or body ...Resident wheelchair was in front of her and noted to be unlocked. Resident has had confusion throughout the day and is upset about current condition of having to stay in room due to being on isolation ...Resident is confused and unable to state what happened ..." There were no new fall interventions documented in R3's Clinical Records for this fall.

6. R41's Face sheet documents an admission date of 02/02/21 and diagnosis including: Parkinson's Disease, Dementia, Muscle Wasting and Atrophy, Lack of Coordination, and Cognitive Communication Deficit. R41's MDS dated 01/30/24 documents a BIMS of 04 indicating cogitation is severely impaired. Section GG documents: dependent for: roll left and right, sit to lying, lying to sitting on side of bed, chair/bed to

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chair transfer, and toilet transfer.

R41's Care Plan with a revision date of 02/14/24 documents: Risk for falls: with falls documented: on 08/25/23 and 02/13/24. R41's care plan does not document any intervention for the fall on 08/25/23. R41's Care plan documents an intervention of MD evaluation for the fall on 02/13/24.

R41's Fall investigation dated 08/25/23 at 9:45 PM documents: Nursing Description - R41 laying on left side on floor mat beside bed, R41 is in a gown and barefoot incontinent of bowel bed in low position no clutter noted R41 assisted to bed per staff no red or bruised area noted. Immediate Action Taken - R41 was assisted to bed, floor mats to side of bed continued, bed in low position continued. Resident taken to the Hospital - No: Injuries Observed at Time of Incident - No injuries observed at time of incident. Level of Pain: Facial Expression - smiling or Inexpressive: body language - Relaxed; Consolability - no need to console. Mental status - oriented to person: Injuries Report Post Incident - no injuries observed post incident. Level of Pain: with nothing documented: Mental Status - with nothing checked: Predisposing Environmental Factors - with nothing checked: Predisposing Physiological Factors: with incontinent checked: Predisposing Situation Factors - with recent room change checked: Other info - with nothing documented: Witnesses - no witnesses found. No intervention was documented on this investigation report.

R41's Nurse's notes dated 08/25/23 at 10:01 PM document: R41 laying on left side on floor mat beside bed, R41 is in a gown and barefoot incontinent of bowel bed in low position no clutter noted R41 assisted to bed per staff no red or

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bruised area noted.

R41's Fall investigation dated 02/13/24 at 7:40 PM documents: Nursing Description: Staff called to hallway by nurse's station R41 laying on floor on right side in pajamas and nonskid socks hall lights on floor dry free of clutter asked res what happened with no response voiced R41 moves all extremities without difficulty. Immediate action taken assessment completed, sent to ER for evaluation. Resident taken to hospital: No. Level of Pain: Facial Expression - sad, frightened, frown: body language - tensed, distressed pacing; Consolability - no need to console. Mental status - oriented to person, Injuries Report Post Incident - no injuries observed post incident. Level of Pain: with nothing documented: Mental Status - with nothing checked: Predisposing Environmental Factors - with nothing checked: Predisposing Physiological Factors: with nothing checked: Predisposing Situation Factors - with nothing checked: Other info - fall from wheelchair: Witnesses - no witnesses found. No intervention was documented on this investigation report.

R41's Nurse's note dated 02/13/24 at 9:53 PM document: Staff called to hallway by nurse's station R41 laying on floor on right side in pajamas and nonskid socks hall lights on floor dry free of clutter asked res what happened with no response voiced R41 moves all extremities without difficulty.

R41's Nurse's note dated 02/13/24 at 9:55 PM document: Fall Details: Fall was not witnessed. Fall occurred in the hallway. Activity at the time of fall: unknown. The reason for the fall was not evident. Did fall result in an ER visit/hospitalization: Yes.

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R41's Nurse's notes dated 02/16/24 at 1:23 PM document: Resident resting quietly in recliner at nurse's station at this time. Alert, pleasant and cooperative with staff. No further injuries noted r/t fall 2/13/24. Bruising continues to right front and back of shoulder, dark purple in appearance to back of shoulder and yellow in front.

On 02/29/24 at 1:50 PM V2 (Director of Nursing) stated, she does not know why the fall investigation for R41's fall on 02/13/24 documents that she was not sent to the hospital, because she was sent out for X-rays, she does not know why it documents no need to console, because she was obviously in pain and was being consoled and she does not know why it documents she was pacing because she does not walk. She did have bruising, but the X-rays were negative. V2 stated she has talked to the nurses about correct documentation.

On 02/29/24 at 2:00 PM, V2 (Director of Nursing) stated, sending to the emergency room does not help prevent future falls.

7. R49's Face sheet documents an admission date of 04/11/2023 with diagnosis including: Dementia, Muscle wasting and atrophy, Abnormalities of gait and mobility, and lack of Coordination. R49's MDS dated 01/23/24 documents a BIMS score of 09 indicating moderately impaired. Section GG documents Partial to Moderate Assistance is needed for: sit to lying, lying to sitting on side of bed, sit to stand, chair /bed to chair transfer, and toilet transfer and walk 10 feet - not attempted and resident did not perform this activity prior to the current illness, exacerbation, or injury.

On 02/26/24 R49 stated he had falls, R49 would

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not give any further information.

R49's Care plan dated 05/16/23 documents falls on: 10/10/23, 11/15/23, 11/25/23, 12/19/23, and 01/25/24 with no interventions documented. R49's fall investigation dated 10/10/23 documents: Immediate action taken - encouraged resident (R49) to use call light and ask for help. R49's Care plan documents an intervention dated 05/16/23 as: be sure R49's call light is within reach and encourage the resident to use it for assistance as needed.

R49's fall investigation dated 11/15/23 at 11:20 AM documents: R49 was noted laying on the floor on his left side with his head rested against right wheelchair wheel. R49 was holding himself up on his left arm. Both lower extremities were extended but slightly bent. Right slipper noted to be hanging off foot. Wheelchair noted to be unlocked. The floor was dry, adequate lighting was noted. R49's roommate was attempting to help him get up, he stated R49 was walking back from the sink and lost his footing and he fell. Immediate Action Taken: assessment completed, neurological check initiated, R49 was assisted back into his wheelchair via two assist and gait belt and encouraged resident to use call light for assistance. R49's fall investigation dated 11/15/23 does not document any new intervention for this fall.

R49's fall investigation dated 11/25/23 at 4:15 AM documents: R49 was found lying on the floor on his right side facing the recliner. R49 stated, he was sitting on the side of his bed and fell asleep and fell forward and hit his head on bedside table. Neurological assessments were done and within normal limits, R49 was able to more all extremities. R49 has a hematoma noted to top of

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head with minimal bleeding, skin tear to right knee measuring 0.3 x 0.3 cm (centimeter), small skin tear to left hand measuring 0.1 x 0.1 cm, small skin tear to left elbow measuring 0.2 x 0.1 cm. Small skin tear to left third knuckle. R49 stated he is just sore. R49 was re-educated on putting light on when needing help.

R49's fall investigation dated 12/19/23 at 5:19 PM documents: R49 was found on his hands and knees. R49 moved to sitting on his buttocks, feet facing the bathroom door. When R49 was asked what he was doing, he stated, "I don't know, trying to get out of bed." Immediate action taken - assessments done, no new areas to knees or hands. His shoes were on, the floor was dry and free of clutter. R49's wheelchair was locked. R49 has been very tired today. R49 denies any pain from the fall. R49's Fall Investigation dated 12/19/23 at 5:19 PM does not document any intervention for this fall.

R49's fall investigation dated 01/25/24 at 4:50 PM documents: Nursing Description: R49 was sitting on his buttocks on the floor in his room facing his recliner with his wheelchair noted behind him in the unlocked position. R49 has his left leg extended and his right leg bent at the knee. The water pitcher was noted to be on the floor and the floor was wet. R49 stated "I slid out on the floor" and " R49 stated he spilled his water and was trying to get up and he slipped out of wheelchair." R49 was brought to the nurse's station to finish his supper with supervision. Neurological checks were initiated. Immediate Action Taken - assessment and investigation completed, neurological checks initiated, R49 was brought to the nurse's station to be supervised while eating. R49's fall investigation dated 01/25/24 at 4:50 PM does not document any intervention for this fall.

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S9999	Continued From page 19 On 2/28/2024 at 2:19pm, V8 (LPN/CPC) said she does not normally do fall interventions and that is usually done by V17 (RN) but V17 has been out on medical leave. Facility policy titled Falls-Clinical Protocol (revision date of March 2018) documents in part, based on assessment the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling, and if underlying causes cannot be readily identified or corrected, staff will try various relevant interventions based on assessment of the nature of category of falling, until falling is reduced or stops. "A"	S9999		