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S 000	Initial Comments Complaint Investigation: #2443242/IL172335 #2443561/IL172828	S 000		
S9999	Final Observations Statement of Licensure Violations: ONE of FOUR: 300.610a) 300.1210b) 300.1210d)5) 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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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.

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:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These requirements were not met as evidenced by:

Based on interview, observation, and record review, the facility failed to assess, measure, document, obtain orders for, prevent the development and worsening of pressure ulcers, and provide pressure ulcer treatment following nursing standards for 1 of 3 residents (R6) reviewed for pressure ulcers. This failure resulted in R6 sustaining a new pressure ulcer and 2 previous pressure ulcers worsening.

Findings include:

R6's Resident Face Sheet, undated, documents that R6 was admitted on 2/29/24 with diagnoses of Dementia with Anxiety and Weakness of the

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S9999	Continued From page 2 Left Side. R6's Minimum Data Set, dated 5/3/24, documents that R6 is severely cognitively impaired, is dependent on staff for all mobility, activities of daily living, does not ambulate and does not have a pressure ulcer. R6's Physician Order Report, dated 2/29/24 - 5/13/24, documents, "Start date 5/7/24. Left buttocks - cleanse and apply medi honey with calcium alginate and cover with border gauze and PRN (as needed) for soiling / dislodging. Once a day." R6's Physician Order Report, dated 2/29/24 - 5/13/24, documents, "Start date 5/7/24. Right buttock - Apply skin prep to area daily for protection. Once a day." R6's Physician Order Report, dated 2/29/24 - 5/13/24, fails to document any order for R6's pressure ulcers before 5/7/24. The Physician Order Report, dated 5/14/24, documents, "Start date 5/14/24. Left buttocks cleanse and apply hydrocolloid 3 times a week and PRN for soiling / dislodging. Start date 5/14/24. Right buttock Cleanse and apply medi honey, calcium alginate and cover with bordered gauze daily and PRN for soiling / dislodging Once a day." R6's April 2024 and May 2024 Medication Administration Record documents that R6 had open areas during a skin check on 4/30/24, 5/1/24 and 5/2/24. R6's Wound documentation fails to document any wounds or pressure ulcers before 5/7/24.	S9999		

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R6's Focused Observation, dated 4/30/24, documents, "Have you reviewed/added Wound Management for any Alterations in skin? Answered yes." This Focused Observation fails to document what the alteration is the skin is.

The Facility Wound Summary Report, dated 5/7/24, documents, R6 has a DTI (Deep Tissue Injury) to the Right Buttock measuring 2 x 1 and it has been present for 8 days. R6 also has a Stage II Pressure Ulcer on the left buttock measuring 1 x 1 x 0.1 which has been present for 8 days.

R6's Wound Management Note, dated 5/13/24, documents, " First observation of area by wound Dr (doctor) (V36, Wound Doctor). Present on re admit from hospitalization. Area with stage 3 ulcer of 1.5x1.5cm (centimeter), hydrocolloid to be applied 3 x (times) a week, with surrounding periwound purple/maroon DTI altogether measuring 10 x 7.5 cm. Area 60% dermis, 20% granulation tissue, 20% skin. Treatment orders in place, offloading and frequent repositioning. Resident on Low air loss mattress."
This Wound Management Note fails to document the size, the appearance, and Stage of the Right Upper Buttock.

On 5/14/24 at 10:10 AM, V14, Director of Nurses, entered R6's room to provide pressure ulcer treatment. With R6 lying on her left side, R6's buttocks were exposed. R6 has a pressure ulcer to the right upper buttock/ coccyx area The area is approximately 2.5 inches (inches) wide by 1 in. long. The top of the pressure ulcer which is approximately half of the pressure ulcer is light brown in color and appears to be hard thickened skin. The other part of the pressure ulcer is a light purple color area which has begun to flake off. The left outer lower buttock has 2 pressure ulcers

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both are the approximate size of a nickel. Both pressure ulcers wound beds are red and have bloody drainage. The periwounds are both slightly reddened.

On 5/14/24 at 10:12 AM, V14 stated that the old dressings were just removed because R6 was provided incontinent care. the left outer lower buttocks pressure ulcer was first identified now and it was not present yesterday evening when (V36) made rounds.

On 5/14/24 at 10:12 AM, V14 washed hands, donned gloves, sprayed wound cleanser on a 4 x 4 gauze pad, and cleanse all three pressure ulcers with the same gauze pad in a swiping motion. V14 removed gloves, performed hand hygiene, applied a hydrocolloid dressing over the left lower buttocks pressure ulcers. V14 then applied medihoney, calcium alginate, and a foam dressing to the right upper buttocks/ coccyx wound. V14 removed gloves and preformed hand hygiene. R6 does have a low air loss mattress in place.

On 5/13/24 at 1:38 PM, V16, Certified Nurse Aide (CNA), stated, "(R6) had a small open area on her butt before she went to the hospital. I can't remember what cheek. We were putting Calazamine cream on it.

On 5/14/24 at 8:52 AM, V14, Director of Nurses, stated, "I was unaware that R6's had an open area before she went to the hospital. If I had known about it I would have got an order for it."

On 5/13/24 at 2:34 PM, V13, CNA, stated, "(R6) had a small pressure ulcer on her butt when she went to the hospital. Now that she is back it has gotten a lot worse, so apparently she isn't getting

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turned properly."

On 5/13/24 at 3:00 PM, V18, Registered Nurse (RN), stated, "(R6) did have a pressure ulcer on her coccyx. I know we were treating it. I think with honey and calcium alginate but I am not sure. I am not sure why there isn't an order. If I see an open area I let the wound nurse know about it."

On 5/14/24 at 11:15 AM, V19, CNA, stated, "(R6) did have a pressure ulcer on her buttocks. We were putting zinc cream on it. There was not a dressing just the cream. It was about the size of you fingertip. She had it a little while before she went to the hospital."

On 5/14/24 at 12:53 PM, V9, CNA, stated, "(R6) did have a small open spot on her buttocks before she went to the hospital.

On 5/15/24 at 6:30 PM, V22, R6's Power of Attorney, previous facility Director of Nurses, stated, "(R6) did have a pressure ulcer on her buttocks before she was put in the hospital. I am not sure what they were treating it with. My last day of work there was 4/19/24 and at that time her buttocks was just red. It was not open."

On 5/16/24 at 9:30 AM, V1, Administrator, stated that R6 should have had pressure ulcer orders before she went to the hospital. V1 stated that the wound doctor measured all three of the wounds as one. V1 stated the pressure ulcers have gotten worse since she came back from the hospital which is probably caused by not turning and repositioning.

On 5/16/24 at 9:40 AM, V14 stated that the wound doctor measurements reflect her documenting all 3 wounds as one. V14 stated

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S9999	Continued From page 6 that she does not have individual pressure ulcer measurements or assessments at this time and the pressure ulcers have worsened since 5/7/24. The policy Wound Management Program, dated 1/20/23, documents, "c. If any new areas are identified, write a nurse's note describing the area found and the protocol followed to treat it, Skin Protocol or New Skin Condition Protocol. d. The new area will be noted on the 24 hour report." It continues, "f. The nurse will measure the area; call physician to obtain appropriate treatment order, call the guardian / family member to inform him / her, document the area on the T.A.R. (Treatment Administration Record), and initiate the treatment." It continues, "All wounds will be reported weekly in their electronic health record. 8. It is important that wounds are assessed correctly to differentiate between pressure and non pressure wounds. The Documentation is to include: a. Pressure Wound Report i.. Resident name ii. Room and Bed # iii. Resident Admission Date iv. Resident location (hall number and letter) v. Site vi. side vii. On set date viii. Origin ix. Stage x. Odor xi. Eschar / Slough xii. Drainage xiii. Drainage amount xiv. Size xv Pressure reducing devices xvi. Change since last assessment xvii. Treatment conditions." (B) TWO OF FOUR: 300.610a) 300.1010h) 300.1210b) 300.1210d)3)	S9999		

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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.

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:

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

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to notify the Physician of a change of condition and delay in diagnostics, timely treat an injury of unknown origin and failed to provide pain management for 1 of 3 residents (R6) in the sample of 11. This failure resulted in R6's ongoing pain and delay of treatment for a fractured leg.

Findings include:

R6's Resident Face Sheet, undated, documents that R6 was admitted on 2/29/24 with diagnoses of Dementia with Anxiety and Weakness of the Left Side.

R6's Minimum Data Set, dated 5/3/24, documents that R6 is severely cognitively impaired, is dependent on staff for all mobility, activities of

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daily living, and does not ambulate.

R6's Progress Note, dated 05/02/2024 at 02:00 PM, which was recorded as Late Entry on 05/03/2024 06:59 PM, documents, "CNA (Certified Nurse Aide) reported swelling and tenderness noticed in residents right knee, reported to writer and floor (V18, Registered Nurse /RN) received and inserted order for knee xray."

R6's Physician Order Report, dated 2/29/24 - 5/13/24, documents, "Start Date 5/2/24. XRAY right knee 2 views AP (anteroposterior) LAT (lateral). Mobile r/t (related to) advanced age and immobility. Dx (diagnosis); Pain, swelling."

R6's Physician Order Report, dated 2/29/24 - 5/13/24, documents, "Start Date 5/3/24. Rt (right) Hip: Special Instructions: Right Hip Xray-pain. Portable due to advanced age and immobility. Dx: Pain."

The facility acquired X-ray, dated 5/3/24, documents, "Impression: Probable distal (away from body) femoral (thigh bone) fracture with effusion (fluid collection) presumably acute (recent onset)."

R6's Progress Note, dated 05/03/2024 at 05:30 PM, documents, "Resident right knee and hip xray results received this afternoon, faxed (V29, R6's Physician) and notified (V22, R6's Power of Attorney/POA) of results, being osteoarthritis, and probable distal femoral fracture. (V30, V29's Nurse) states received results at office but (V29) had left office for day. Residents family would like resident sent to ED (Emergency Department) eval (evaluation) for another xray, eval and pain management. Writer called (local ambulance

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service) and (local hospital). taking resident to ED at this time with family following, paperwork sent with EMS (Emergency Medical Services)."

R6's Progress Note, dated 05/04/2024 at 03:26 AM, documents, "ER (Emergency Room) nurse called to inform writer that resident is being admitted for pain management and right femur fracture."

The local Hospital Clinical Report, Registration date of 5/3/24, documents, " History of Present Illness: Chief complaint; right lower extremity pain. This started yesterday and is still present. Patient is a 68 year old female with past medical history of dementia/ nonverbal/ non ambulatory. (full mechanical lift) presenting from (the facility) with complaints of right lower extremity pain that started yesterday some time with no known injury. There was an outpatient x-ray done which showed a possible distal femur fracture. There is no known repeated fall or trauma." It documents "She does endorse a lot of pain with movement of right extremity or any movement."

The Hospital Radiology Report, dated 5/3/24, documents, " Exam: CT (Computed Tomography) of the right knee. Impression: There is a mild impaction type fracture of the lateral (outside) femoral (thigh) condyle (the end of the thigh bone which connects to the knee)."

R6's Hospital Discharge Summary, dated 5/7/24, documents, "Non weight bearing on Right lower extremity, right knee immobilizer for 6 weeks recommended per orthopedics while in Emergency Department."

On 5/13/24 at 1:38 PM, V16, CNA, stated, "(R6) is dependent on staff for all cares. She transfers

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with a (full mechanical lift). I work the day shift 6 AM to 2 PM. On 4/30/24 she was fine. I was off on 5/1/24. When I came back on 5/2/24 (Thursday), she was screaming in pain and holding her leg when we (V16 and V19 CNA) tried to get her up and dressed for the day. We were trying to put her pants on and once it got to her shins she started screaming. The knee was extremely swollen. I went and told the nurse. I don't remember who it would have been the nurse on A hall (V18, Registered/RN). I work a lot. We left in her in bed. When we provided care for her during the day, she would grab leg and scream out. I think they sent her out by Friday."

On 5/13/24 at 2:34 PM, V13 CNA, stated, "(R6) requires total care. She has minimal speech. I believe it was Thursday (5/2/24) that I worked with her. She would make facial grimaces with cares. We were told to leave her in bed. Her knee was swollen with a small bruise that was forming."

On 5/13/24 at 3:00 PM, V18, Registered Nurse (RN), stated, "During change over from the night shift to my day shift, night shift stated that there was a little red spot and swelling on (R6's) knee. I went with (V19, CNA) I think, and I assessed her leg. She had a little swelling to her knee and quarter size red spot. I touched it and she didn't flinch. The day shift CNAs did not mention anything to me about her showing signs of pain. The evening shift 2 PM to 10 PM let me know that she was in pain. I told them to just leave her in bed and I called the Dr for an order for an X-ray. I called (the X-ray company) and they told me they would come in the morning because they were busy. She was wincing in pain at the time with movement. I did call (V22, R6's Power of Attorney (POA)) and let her know. She actually came in

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and looked at her knee and agreed to monitor and get X-ray in the morning. She has scheduled Ibuprofen for pain. I honestly don't know if it helped her or not. I honestly did not think that it was as bad as it was. Especially an impacted fracture, that is a lot of trauma. That is why I didn't send her to the Emergency Room for an X-ray."

On 5/14/24 at 11:15 AM, V19, CNA, stated, stated, "I worked with (R6) on 4/30/24 and she was fine. I was off on 5/1/24. When I came back on 5/2/24 in report I got that she had a red mark on her right knee. I and (V9, CNA) got (R6) dressed and up for breakfast and she was fine. I didn't notice that she was having pain. After breakfast around 9 AM - 10 AM, we went to lay her back down and change her. She was making noise. I could tell she was in pain. I have worked with her enough to know her. I asked if she was in pain, and she said yes. Her knee was a little swollen. I let the nurse (V18) know. She told us to lay her down and keep an eye on it. She said that she was going to check on it too. Me, (V19), and (V17) all went to get her up for lunch. She acted like she was in more pain, and it was more swollen. I then refused to get her up. I told (V18). She went down and assessed it. She said that she was going to get an X-ray. At supper she was still in pain. She was moaning and making noises, so we left her in bed. I left at 6 PM. On Friday (5/3/24) she was the same. She got her X-ray around 10:45 AM."

On 5/14/24 at 12:53 AM, V9, CNA, stated, "On 5/2/24 I worked with either V17 CNA or V20 CNA. We were getting people up for breakfast and she was yelling "ow" (sic ouch). Her knee was huge. If we stopped touching it, she would stop. I went and told the nurse (V18), and she came down

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and looked at it and said she would notify the doctor. The next thing I know is she was sent out. We didn't get her up for any meals."

On 5/14/24 at 2:55 PM, V14, DON, stated, "On Wednesday 5/1/24 night, I was told by V35 Licensed Practical Nurse (LPN) that (R6) had swelling and redness to the right knee and when (V35) assessed the knee (R6) would react. On 5/2/24, (V35) passed it onto (V18) the day nurse. (V18) came to me that (R6's) knee was swollen and that she had gotten an order for an Xray. The next morning (5/3/24) they came and took the Xray. I got the results in the afternoon. I notified (V22, R6's POA) of the probable fracture. I faxed the results to the doctor and called the doctor's office, but the nurse said he was gone for the day. (V22) came in shortly after that and she wanted to see if we could get something for pain control. Her other daughter came in (V15) and wanted her sent to the hospital for pain control and another Xray. I called for transport and sent her to the hospital. (V22) was concerned because the night before (5/2/24) she had visited and (R6) was yelling out in pain when moved and (V22) was worried it was the right hip. She had contacted me and requested a hip xray on Thursday, so I put in an order for a hip Xray to be done too." V14 was questioned as to why the Doctor was not notified in delay of Xray and having increased pain, V14 stated, "I didn't think about it but yes the Doctor should have been notified."

On 5/14/24 at 6:30 PM, V22, R6's Power of Attorney, stated, "I had been notified that my mom had a red area and a swollen knee. I was told they were going to get an Xray. My sister (V15) and I went in to see her the evening on 5/2/24. Her right knee was red and super swollen.

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It was sore to the touch. She would yell and grimace with touch and or when she was moved. My sister and I went to change her. She started yelling. I asked her if it was her hip and she said hip. I let (V14) know that I would like an Xray of the hip. Friday (5/3/24) I was notified that it was a probable fracture. I then requested that she be sent out to the hospital for pain control and evaluation. On Wednesday, when I saw her, I didn't think fracture. I was thinking maybe an abscess or cellulites. I didn't think she need to go to ER (Emergency Room) then."

On 5/15/24 at 5:30 AM, V31, CNA, stated that she worked on 5/1/24 the 10 PM to 6 AM shift. V31 stated on her first bed check with R6 she noticed that was red marks to the middle of the right-side rib area, the left knee, and the right knee. V31 stated at this time there was no swelling. On the second bed check, the red mark on the rib area and left knee were gone. V31 stated the right knee was red but not hot to the touch. V31 stated at this time, R6 did not seem to be having pain. By the time the 5/2/24 day shift came in. The right knee was swollen and hot to the touch. R6 was yelling out with pain with movement. I then worked again on Thursday 5/2/24 night shift. V31 stated R6 was in a lot of pain when she was rolled and provided incontinent care. V31 stated the right knee was red and still swollen.

On 5/15/24 at 9:00 AM, V4, CNA, stated, "On 5/1/24 the evening shift we were short staffed. We had 3 CNAs for the building. Around 4:30 PM or 5:00 PM, (V13 CNA) and I got R6 up using the full mechanical lift. Her family came in and fed her dinner. I ended up putting her to bed around 8:30 PM - 9:00 PM. She seemed normal. She doesn't speak much. She wasn't moaning or

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anything. I did use the (full mechanical lift) to transfer her to bed. I did it by myself. We only had 3 people in the building. I just wanted to get her to bed. The transfer went well. I didn't hurt her. She didn't bump anything. She didn't hit the side rails."

On 5/16/24 at 9:30 AM, V1, Administrator, was questioned if she believed R6's Physician should have been notified of increased pain and that the Xray would not be taken until 5/3/24 morning, V1 stated that the Physician should have been made aware of the increased pain and the delay in Xray.

R6's Physician Order Report, dated 2/29/24 - 5/13/24, documents, "Start Date 2/29/24. Aleve tablet; 220 mg (milligram): 1 oral. Special Instructions: BID (twice daily) PRN (as needed)."

R6's Physician Order Report, dated 2/29/24 - 5/13/24, documents, "Start Date Motrin IB (ibuprofen); tablet 220 mg; amt (amount): 2; oral. Dx: Pain. Four times a day."

R6's May 2024 Medication Administration Record M documents that R6 had a pain scale of 4 (on the 1 to 10 pain scale which indicates 1 is low pain and 10 being the worse pain) on 5/3/24 and R6 did not receive any PRN pain medication. This same MAR documents that R6 did not have any pain on 5/1/24 and 5/2/24.

On 5/16/24 at 3:02PM, V45, Medical Doctor, stated he knows he got a called on R6's fracture leg and we sent R6 to the ER and thought that the ER found it (fracture). V45 stated he can't remember the details, and this is the first kind of injury he's aware of. V45 stated he can't remember when he knew about R6's pain increasing but his (V45) reaction would be to

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send R6 to the Emergency Room. V45 stated the first I heard of R6's fracture was from the ER (emergency room), or maybe from his nurse or had a message to send R6's in, and that V45 couldn't recall.

The facility policy Change in a Resident's Condition or Status, dated 11/16, documents, "d. A significant change in the resident's physical / emotional / mental condition psychosocial status to either life threatening conditions or clinical complications." It continues, "g. A need to transfer the resident to a hospital / treatment center."

The policy Pain Prevention and Treatment, dated 10/2017, documents, "Procedure: 1. Each resident will be assessed for pain using the Pain Screen including an appropriate Pain Rating Scale upon admission and at least quarterly. Residents who are not able to communicate verbally or have cognitive deficit that precludes them from answering yes/no questions will be screened using the Pain Observation Screen including the FLACC (face, legs, activity, cry, consolability) scale."

(A)

THREE OF FOUR:

300.610a)
300.1210b)
300.1210d)6)
300.1230e)
300.2210b)2)
300.2900d)2)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and

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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 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.

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.

Section 300.1230 Direct Care Staffing

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S9999	Continued From page 18 e) The facility shall schedule nursing personnel so that the nursing needs of all residents are met. Section 300.2210 Maintenance b) Each facility shall: 2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems. Section 300.2900 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to provide supervision for residents who require supervised leave and have the potential for elopement for 2 of 2 residents (R5 and R8) reviewed for supervision to prevent accidents in the sample of 11. This failure resulted in R8 leaving the facility unsupervised, being found by a citizen walking on the road a block from facility at 10:48 PM. This failure has the potential to affect all residents in the facility.	S9999		

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This failure resulted in R5 leaving the facility being found on the ground by local police department at 9:08 PM, .6miles from the facility.

Findings include:

1. R5's face sheet undated documents admit date of 12/25/2023 with diagnoses of Parkinsonism, unspecified, Diabetes mellitus due to underlying condition without complications, Chronic obstructive pulmonary disease, unspecified, Hyperlipidemia, unspecified, Chronic thromboembolic pulmonary hypertension, Insomnia, unspecified, 2019-nCoV acute respiratory disease (History of), Unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.

R5's Minimum Data Set dated 4/9/2024 documents R5 is moderately cognitively impaired and needs supervision with Activities of Daily living.

R5's progress noted dated 04/28/2024 at 10:03 PM by V3 (Registered Nurse) documents the following: At 9:08 PM, Local Police called to ask if a resident was "missing" from the facility. V2 (Registered Nurse) was unaware of any missing resident but stated that we would do room checks and call back if we were. At 9:13 PM, prior to CNAs being able to conduct room checks, Local Police called back to ask if we had R5 as a resident. Dispatcher explained that police observed the R5 fall onto his backside near a local park, where he was walking towards the downtown area with his walker. At approximately 9:30 PM, Local Police arrived at the facility with R5, who explained that his brother-in-law passed away, and so he wanted to go see his nieces to

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"make sure they were ok." Further investigation reveals that at approximately 8pm, R5 was observed shaving with an electric razor in his room by a V4, Certified Nursing Assistant, CNA. Prior to this, during dinner, R5 suggested to V4 that a family member was going to pick him up in the evening, and V4 suggested that R5 communicate with his nurse on duty. Per the nurse working that hall, the resident made no mention of his intentions to leave, and he was given his evening medication prior to leaving, per the nurse responsible for his hall. The situation was reported to V14, and then spoke with V1, the Administrator, via phone, to explain the situation. 15-minute bed checks have been initiated. A thorough assessment of R5 reveals no injury.

On 4/30/2024 at 12:30 PM R5 stated that he walked out the front door the other night. R5 stated he was confused and was trying to find his sister. R5 stated that he had to sat down on the road because his legs were hurting so bad. R5 stated there was no sidewalk so I just walked on the road. R5 stated he left about 8:15 PM and was gone about an hour. R5 stated it was kind of dark out when he left. R5 stated he knows to press the button on the front door to get out. R5 stated he told one of the CNAs that he was going to leave. R5 stated he signed out in the book that he was leaving.

On 4/30/2024 at 1:00 PM it was noted that the resident sign out book contained an undated document with R5's name and time on it.

On 5/1/2024 at 9:55 AM V4 stated she was the CNA on R5's hall on 4/28/2024 on second shift. V4 stated that she was the only CNA on that hall that night. V4 stated that there were only 3 total CNAs on second shift for 72 residents that

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evening. V4 stated that she saw R5 in his room between 7-730pm shaving. V4 stated she thought this was unusual, so she asked him what he was doing. V4 stated that R5 said he was going to leave that his sister was coming to get him. V4 stated that she thought this was odd that R5's sister would be coming to get him at this time of night. V4 stated that she walked by R5's room about 7:45PM- -8pm and R5 was sitting in his recliner chair. V4 stated she was down another hallway helping another CNA lay down residents that required two assist to get into bed and was told that R5 had gotten out of the building and the police were bringing him back.

On 4/30/2024 at 10:00 AM, V2, Registered Nurse, stated that on 4/28/2024 he was at the end the end of the hallway and the phone kept ringing, so he went to answer it and it was the local police department. V2 stated the police department asked if they were missing any male residents. V2 stated he responded, 'Oh God I hope not but we are severely understaffed so I will have to check with the CNAs." V2 stated that just a few minutes later the police called back and asked if R5 was our resident. V2 stated "I stated 'yes' and they said they witnessed him at the park fall to his bottom and they assisted him up. Police asked if someone could come get him and I stated no we don't have enough staff." R5 returned to facility via police vehicle and was pleasant and uninjured. V2 stated he was not sure how R5 had gotten out of the building but that R5 is pretty steady on his feet with his walker.

On 5/13/2024 at 11:38am V10, Social Services Director, stated that there is only one resident that is allowed to leave independently and that all other residents need to be supervised to leave.

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Local Police Department, dated 5/1/2024, documented the address of where R5 was located on 4/28/2024.

Electronic Mapping application documented that R5 was 0.6 miles from the facility on 4/28/2024 using the address provided by the local police department on 5/1/2024.

2. R8's face sheet undated documents admit date of 3/10/2024 with diagnoses of congestive heart failure, unspecified dementia, psychotic disturbance and anxiety and depression.

R8's Minimum Data Set (MDS) dated 2/25/2024 documented R8 is moderately cognitively impaired. MDS documents that R8 needs supervision with walking 150feet.

R8's elopement evaluation dated 2/13/2024 documents that R8 is ambulatory, is a new resident who is questioning the need to be here, doesn't understand why she is here, and that elopement care plan was not initiated.

On 5/13/2024 at 2:33 PM V13, Certified Nursing Assistant, CNA, stated that R8 had tried to get out the front door about 4:00 pm on 5/11/2024 and V13 was able to re-direct her back away from the door. V13 stated that she told V2, Registered Nurse, about it. V13 stated that around supper time that same evening the alarm for door B went off and R8 had attempted to exit door B again. V13 stated that R8 was easily directed again back into facility. V13 stated that when she was leaving around 10:00 PM that R8 was near the breakroom door and V13 encouraged R8 to go back to the nurse's station.

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On 5/14/2024 at 9:00 AM V5, CNA, stated that R8 was wandering into other residents' rooms on the date of 5/11/2024. V5 stated that one of the residents was yelling "get out of here" and that V5 entered the room to find R8 in there and re-directed R8 out of the room.

On 5/14/2024 at 8:50 AM V2, Registered Nurse, RN, stated that on the evening of 5/11/2024, R8 had went up to the front door when V13, CNA was leaving and V13 re-directed R8 back to the nurse's station. V2 stated that R8 is not normally that confused. V2 stated that R8 doesn't typically exit seek. V2 stated that R8 is pleasantly confused. V2 stated that R8 is independent with ambulation and her walker within the facility. V2 stated he is not aware of any door alarms going off because of R8 on that evening. V2 stated he does not know the protocol for what to do if a resident is actively exit seeking. V2 stated it very difficult for staff to monitor residents due to low staffing numbers on second and third shifts. V2 stated door alarms, resident personal alarms and the front door alarms go off multiple times in a shift and staff become fatigued to them.

R8's Progress Note, dated 05/11/2024 at 11:39 PM, written by V23, Licensed Practical Nurse, LPN documents a call was made to the facility stating a resident was walking down Houston Street with a walker. Some staff immediately started doing a head count and other staff went outside. At 10:48 PM as V23 and some staff was out front looking, 2 cars pulled up into parking lot. One car had the R8 inside and the other car had the R8's walker. V23 assessed resident, no concerns noted. R8 stated she was going home and said she left out the door and pointed to the back door on B-wing. V1 notified. V14, DON, notified. POA called and V23 left message. V23

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last seen resident at about 10:10 PM. walking down B-wing with her walker.

On 5/14/2024 at 10:51 AM, V23, LPN, stated that R8 was wandering up and down the halls when V23 came on shift. V23 stated that R8 had walked up to the front door and was re-directed back to the nurse's station with a snack. V23 stated that R8 then walked back down the B hallway towards her room this was about 10:30 PM. V23 stated that around 10:50 PM one of the CNAs answered the phone and the caller asked if the facility was missing anyone that they had seen someone walking down the street in all black with a walker. V23 stated a staff member went to the front door and a citizen pulled up with R8 in the car. V23 stated that the citizen stated that R8 was two streets over when she saw R8. V23 stated that R8 stated that she went out B door. V23 stated that staff opened door B and the alarm did not go off so they called the maintenance man and blocked the door so no one else could get out of it. V23 stated that the staff shut the lights off at shift change. V23 stated she is not aware of the policy for exit seeking residents but was told what to do after R8 go out of the building.

Facility provided Event Report dated 5/11/2024 documents event date as 5/11/2024 at 11:26 PM. This document documents R8 was found about approximately one block north of the facility, R8's mental status as confused and other-possible urinary tract infection.

On 5/14/2024 at 2:00 PM observations of the outdoor environment noted the sidewalk outside exit door B contains contained sloped areas and uneven sidewalk. The street in front of facility is found to be uneven, contains loose gravel in

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areas and numerous potholes. The street does not have a sidewalk and ditches are noted to be deep.

On 5/14/2024 at 12:20 PM V14, Director of Nursing, DON stated that R8 was more confused than her normal on the night of 5/11/2024. V14 stated that R8 typically goes to her room after supper and stays there the rest of the night. V14 stated that around 10 PM R8 was given snacks and then R8 walked back down towards her room (down B hall).

On 5/13/2204 at 1:00 PM V14 stated that on the evening of 5/11/202,4 R8 said she was going home when R8 was found outside.

On 5/13/2024 at 8:35 AM V1, Administrator, stated that R8 was found outside the building by a citizen this weekend. V1 stated that R8 told the staff that she went outdoor B, and the staff said the alarm did not go off. V1 stated they depend on the door alarms to tell us if someone is exiting.

On 5/14/2024 at 10:06 AM V1 stated that around 11:00 PM R8 was brought back to facility by a citizen driving by the facility. V1 states R8 was found by this person at the 4-way intersection standing next to the stop sign. V1 stated that the citizen put R8 in her personal car and drove her back to the facility. V1 stated that this citizen called the facility and asked if the facility was missing anyone. V1 stated that 3 aides when out to the car and assisted R8 into the building. V1 stated that R8 has had exit seeking behavior that night before this occurred. V1 stated R8 exited building out B door and that staff said the alarm was not sounding. V1 stated "We don't know how she got out because no alarms were sounding." V1 stated the door alarms were not working

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correctly. V1 stated she was not aware of R8 exiting out B door earlier in the shift. V1 stated that the Door B alarm was not working. V1 stated 15-minute checks were initiated after R8 was found outside, wander guard applied, and all exit doors were all checked that night.

On 5/14/2024 at 10:24 AM V24, Maintenance Director, stated that he received a call from the facility on 5/11/2024 around 11PM and said that door B was not alarming. V24 stated he arrived at the facility and went to check door B. V24 stated that door B has two alarms on it, one that can only be cancelled with putting the code in the keypad and one that is battery operated. V24 stated the lights in the hallway were shut off and he noticed that the exit light above door B was not lit up and that the keypad was not lit up. V24 stated he pushed Door B open, and no alarm sounded, so he checked the battery-operated alarm and replaced the battery on it. V24 stated that alarm then sounded when he opened the door. V24 stated that he discovered that the keypad alarm to that door is disabled when the hall lights are shut off. V24 stated he checks the door alarms for proper functioning every week and that door B worked fine on Tuesday of this week. V24 stated that the keypad alarm is connected to the alarm panel at the nurse's station and sounds an alarm at the nurse's station. V24 stated that he does not have the battery-operated alarms on any kind of checks and does not regularly check batteries on theses alarms.

On 5/15/2024 at 8:47 AM V24 shut light off down A hall and opened exit door with no alarm sounding. V24 stated that he was not aware of the door alarm not sounding when door A was opened while the lights are off. V24 stated that

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door A does not have a backup battery alarm attached to it.

On 5/15/24 at 5:40 AM, V31, CNA, stated, "On of my coworkers did a bed check on her. She gave her a bag of chips and then (R8) went back to her room. Later I answered the phone and the person asked if we were missing someone. I said I don't think so but let me check. She told me it was a lady, wearing all black, and she had a walker. I let my coworker (unidentified) know about the call. It took us about 5 minutes, and we figured out that it was (R8). I let the caller know and they brought her back. (R8) stated that she was fine, went out the back door, and didn't fall by the grace of God. She does exit seek. We try to redirect her. We will get her a snack. We will bring her up to the nurse's station and she sits with us."

On 5/14/24 at 6:00 PM, V34, CNA stated that she did not know the B hall exit door was turned off when the lights were turned off and a battery powered alarm was secondary. V34 further stated that the lights are usually turned off around 9:00 PM.

On 5/15/24 at 5:40 AM, V31, CNA, stated that she did not know the B hall exit door was turned off when the lights were turned off and a battery powered alarm was secondary.

On 5/15/24 at 5:45 AM, V32, CNA stated that she did not know the B hall exit door was turned off when the lights were turned off and a battery powered alarm was secondary.

On 5/15/24 at 9:00 AM, V4, CNA, stated that she did not know the B hall exit door was turned off when the lights were turned off and a battery powered alarm was secondary.

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On 5/15/2024 at 9:42 AM, V1 stated that V24 made her aware last night that door A hall exit door does not alarm when lights are off and door is opened.

On5/14/2024 V13 stated that the staff shut the lights off on the hallways around shift change 10pm

On 4/14/2024 at 3:35 PM V10, Social Service Director, stated she was not aware that the exit door B alarm did not work when the lights are shut off.

On 5/14/2204 at 3:42 PM V3, Licensed Practical Nurse stated that she was not aware that the door alarm did not work down hall B when the lights are off.

On 5/14/2024 at 3:35pm V1 stated she knew earlier this week that the exit door B alarm did not work when the lights are off.

On 5/14/2024 at 3:40pm V27, CNA, stated that she was not aware that door B alarm did not sound when the lights are off on the hallway.

On5/14/2024 at 3:40pm V28, CNA stated she knew on Sunday 5/12/2024 that the alarm on door B did not work when the lights are shut off, but that maintenance came in and fixed it so that it works now.

On 5/14/2024 at 3:30 PM V25, CNA stated that he was not aware that the exit doors on the hallway do not alarm when the lights are shut off on the hallway.

On 5/14/2023 at 3:00pm V14, DON, stated she

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was not aware that door B alarm did not work when the lights are turned off.

On 5/13/2024 1:00pm V1 stated that on 5/11/12024 when R8 got out the Door B alarm was not sounding and that the staff trust the alarms to tell them when a resident is exiting.

On 5/15/2024 at 8:47 AM paper sign taped to wall next to light switch states DO NOT SHUT LIGHTS OFF (even at night) on hall A and Hall B.

On 5/14/2024 at 10:24 AM V1 and V24 stated they do not have a policy on checking exit doors.

On 5/13/2024 at 10:45 AM V10, Social service Director, stated that they really don't have any systems in place to monitor doors, that doors have alarms, and everyone should be aware. V10 stated everyone should be aware of re-directing residents that are attempting to exit doors. V10 stated it is that way for all shifts. V10 stated that if the resident tells the CNA they are leaving the CNA should tell the nurse so the nurse can prepare meds for leave if needed. V10 stated that cognitively impaired residents are assessed upon admission and quarterly for exit seeking. V10 stated that if residents experience wandering/exit seeking behavior between quarterly assessments the floor staff are to document that behavior. V10 stated if the resident is found to be exit seeking the resident will get a wander guard. V10 stated the wander guard alarm is only on the front door but all other exit doors have alarms. V10 stated that R8 walks with a walker and has had no previous exit seeking behavior.

On 5/14/2024 at 10:06 AM V1 stated that if staff were aware of R8 actively exit seeking that she expects staff to monitor her more closely. V1

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stated that she defines monitoring as making sure that R8 is here, that they know her whereabouts and possibly initiated 15-minute checks.

On 5/14/2024 at 12:20 PM V14 stated that she expects staff to keep residents who are exit seeking, in view at all times and put wander guard alarm on them.

On 5/15/2024 at 11:01 AM V26, R8's Physician, stated that the elopement on 5/11/2024 of R8 shouldn't have happened, that she was not even aware of R8's elopement until Sunday 5/12/2204 when the facility called to report R8's increased confusion and V26 sent R8 to the hospital. V26 stated that R8 has significant dementia and R8's safety is at risk because the street in the front of the facility is very busy. V26 stated she expects the facility to have systems in place to supervise R8 so that R8 does not exit facility unsupervised.

Facility provided policy dated 1/2018 titled Elopement prevention policy documents that door alarms will be checked daily by maintenance for function. This document states the facility will provide a safe and secure environment for the resident.

On 5/2/2024 at 9:00am V1, Administrator, stated she expects her staff to supervise residents and know if they are leaving the building.

The facility's matrix, dated 5/1/2024, documented that there were 71 residents residing in the facility.

(B)

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S9999	Continued From page 31 FOUR OF FOUR 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)6) 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 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. Restorative measures shall include, at a minimum, the following procedures:	S9999		

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S9999	Continued From page 32 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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 use alternatives to bed rails, and assess and monitor for risks including injury and entrapment related to the use of bed rails for 3 of 3 residents (R7, R10 and R6) reviewed for bedrails in the sample of 11. This failure resulted in R7's right arm being caught in the bedrail during care resulting in R7's fractured arm and decline in R7's overall physical condition. In addition, R10 was observed several times with her arm through the right bedrail on her bed. R10's documented history of dementia with behavior disturbances, hallucinations, and	S9999		

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psychiatric history put R10's entrapment of her right arm through the bedrail at an increased risk of injury.

Findings include:

1. R7's undated Face sheet documents R7 was re-admitted on 8/22/2021 with a diagnoses of dementia, primary osteoarthritis right and left knee, age related osteoporosis, dorsalgia, unspecified hearing loss, history of falling, dependence on wheelchair, contracture of muscle, multiple sites, contracture, left and right hip, left and right knee, unspecified fracture of shaft of humerus, right arm, sequela, and dysphagia.

R7's Physician Order Report dated 11/19/2018-5/13/2024 does not document an order for bedrails.

R7's Progress Notes dated 4/21/24 at 5:21PM documents: "staff called writer to res (resident) room stating that while changing and dressing res before dinner, she hooked her arm in the bed rails when turning and there was a pop. Writer went to assess and found res laying in the bed on her left side, there is a large area between the right shoulder and right elbow to be raised about 2 inches. Res is able to move fingers. Does not appear to be in pain; does not appear to be in distress. Ambulance was called and res is being send to ER for eval and tx (treatment). Writer left message for POA as there was not answer. Writer spoke with emergency contact and informed of above. He states he will meet res at ER. Ambulance provider en route to transport. "

R7's Minimum Data Set dated 4/2/24 documents R7 has short- and long-term memory problems,

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Brief Interview for Mental Status is left blank, and severely impaired decision making. The MDS documents R7 uses wheelchair with no impairment to upper extremities and impairment on both sides of lower extremities and is dependent upon staff for activities of daily living. R7's MDS further documents R7 requires substantial/maximal assistance for rolling left and right.

R7's Care Plan dated 4/18/24 documents an approach start date of 10/6/2022 "I prefers to have upper bilateral ¼ rails up while I am in bed to reduce anxiety so I can assist myself when I am able with turning and repositing. The Care Plan further documents an approach start date of 10/5/2022 "Siderails: ¼ up x2 to enable bed mobility. I lay on the very edge of my bed. I even scoot down past my rails or with my head down towards the foot board." On 7/8/2022 an approach to "talk to me while providing care." There are no risk versus benefits documented for the use of R7's. The 4/21/24 Approach documents to ensure bed rails are padded to prevent injuries (Day of injury).

R7's Most recent side rail Assessment, dated 1/6/24, documents type of slide rails indicated: "both" to allow for increased bed mobility, safety risk with use of side rails "none". There is no side rail assessment for the quarterly 4/2/24 reporting period.

R7's Progress Notes dated 4/21/24 documents R7 went out to hospital per family preference after R7 had "hooked her arm in the bed rails when turning and there was a pop" and returned on 4/22/24 with a closed displaced fracture on the shaft of the right humerus.

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R7's Emergency Room Radiology report dated 4/21/24 documents: "History: Patient rolled in bed and arm caught in rail. Obvious deformity. Findings: There is an overriding apex laterally angulated midshaft fracture of the humerus. The proximal humerus is not visualized in entirety given the patients limitation with positioning. Distal humerus on a single view is grossly unremarkable. Impression: Suboptimal position given patients body habitus however there is a overriding angulated midshaft humeral fracture."

R7's Emergency Room record documents R7 was treated for a closed displaced transverse fracture of the shaft of the right humerus and received 2mg (milligrams) Morphine IVP (intravenous push), 50mcg (micrograms) Fentanyl IVP and Zofran 4mg IVPR. R7 was sent back to the facility with hydrocodone/acetaminophen liquid 10mg/325mg/15ml, take ten (10) ml orally every 6 hours for 3 days.

R7's Facility Reported Incident Report dated 4/22/24 documents, "the caregiver stated that they were providing incontinent care and depressing the resident to go to the dining room for dinner. The resident's arm had slipped between the siderail and her mattress. The CNA (Certified Nurse's Assistant) stated they heard a "pop" from residents' arm. Upon immediate assessment by the RN, a 2 cm raised area was noted between the resident's right shoulder and R7's elbow. R7 displayed no signs of pain or discomfort during assessment. MD was notified of incident and orders were received to send to ER for further assessment of resident injury. R7's Power of Attorney was notified and stated would meet resident at the ER. The ambulance was then called for transport. R7 returned to the

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facility at approximately 9:00PM with diagnosis of a closed, displaced fracture of the shaft of her RT (right) humerus. R7 had a splint in place an new orders for pain medication. R7 received pain medication while she was in the hospital. R7 has a follow up appointment with Ortho MD in 1 week."

R7's Witness documentation, undated include an undated statement from V25, CNA documents "I (V25) checked and changed her (R7) by myself. (V34, CNA) was walking by when I asked for help for the transfer. We started transfer with (V34) on residents left and I was on her rights. I had her cradled with her arm around me when we went to lift up and we heard a snap. V34 went and got nurse."

R7's Witness documentation dated 4/21/24 written by V34 documents "I was asked by (V25) to help transfer a resident to her wheelchair. We had her on the side of the bed about t transfer when the arm she had around V25 (her right) grabbed for the siderail, but her arms was stuck, and we heard a pop. We immediately laid her down while V25 supported her arm, and I went and got a nurse."

R7's Witness documentation, undated, statement from V41, CNA documents "I walked in with the nurses saw residents' arm. I said I would assist with getting her (R7) in a gown because the nurses were on the way to send her out to hospital."

R7's Progress Notes dated 4/27/24 documents "pain medicine given with morning med administrations, as pain was evident upon repositioning. R7 did eat some breakfast and drank some med pass with meds.

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R7's Progress Notes dated 4/28/24 documents "pain medicine given with morning med administration, as pain continues to be evident upon repositioning.

R7's Progress Notes dated 4/30/24 documents "...splint intact to RUE. Noted edema to right arm."

R7's Progress Notes dated 4/30/24 documents "...medicated for pain this am, splint in place. arm swollen and discolored..."

R7's Progress Notes dated 5/2/24 and 5/4/24 documents R7 arm remains edematous and discolored.

R7's Progress Notes dated 5/5/24 documents: "Tylenol given for slight temp tonight."

R7's Progress Notes dated 5/6/24 documents R7 not responding as normal. BP (blood pressure) 117/62, P (pulse) 104. Daughter notified of change in condition.

R7's Progress Notes dated 5/7/24 documents at 1:20PM, R7 still not responding well. Holding food and drink in her mouth. Decision made to keep resident here and just keep R7 comfortable. At 7:39PM, Progress Notes continue R7 condition appears to be declining. No response to verbal or tactile stimuli. Vitals stable. No s/s of discomfort noted. Daughter leaving at this time. To call if any changes.

R7's Progress Notes dated 5/8/24 documents R7 continues to be unresponsive. Family members here this morning. R7 is unable to accept anything by mouth. Family was asking for pain

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medication, so writer went into room and discussed in detail why Hospice is worth consideration in this scenario. Family said they would reach out if they wished to discuss further.

R7's Progress Notes dated 5/8/24 at 12:21PM, documents writer went and spoke with family about Hospice. They would like to go ahead and move forward with hospice. They would like to keep her comfortable as much as possible. Writer is working on faxing information and getting and order from the Dr. for hospice.

R7's Physician Order Sheet documents on 5/8/24: hospice to eval and treat.

R7's Progress Notes dated 5/8/24 at 6:58PM, R7 admitted to hospice.

R7's Visit Note Report dated 5/8/24 documents: Hospice start of care. R7's Visit note further documents: indicate clinical evidence of advancing illness: change in level of consciousness, decline in systolic blood pressure relative to baseline, decreasing oral intake, recent decline in functional status, worsening vital signs. Indicate existing equipment/supplies present in the home (mark all that apply): bedrails, hospital bed, Hoyer lift, overbed table oxygen concentrator. Narrative: R7 is a 100-year-old female patient residing at facility coming on to service with the primary diagnosis of Alzheimer's disease secondary diagnosis of dementia co morbidity to include right humorous fracture. R7 was diagnosed with dementia and Alzheimer's approximately 5 years ago, however 2 weeks ago, patient had a fracture of her right humorous that could not be fixed surgically. R7 was returned to the nursing home. R7 has had a steady decline since patient has been NPO (nothing by mouth)

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for the past 2 days. Minimally responsive upon admission, R7 is now comatose, R7 lungs clear with rapid shallow respiratory rate of 40. Absent bowel sounds, heart sounds are unable to be heard. Blood pressure, unable to be taken. R7 has bilateral lower extremity mottling up to her knees from her toes. R7 had a BM (bowel movement) time 2 today, severe temporal wasting noted, patient place on 3 liters of oxygen per nasal cannula..".

R7's Progress notes dated 5/8/24 at 10:06pm documents R7 transitioned at 1916 with family by her side. Hospice nurse was called who then called the coroner. Granddaughter was on the way to facility so writer told hospice nurse she would call when family was ready. Funeral home was then called at 2120 and picked up at 2149.

On 5/14/24 at 2:40 PM, V25 CNA, was questioned how the injury to R7's right arm occurred. V25 stated that R7 was extremely contacted with her knees bent up and her spine was like a C shape. V25 stated that he had provided incontinent care for R7. V34 CNA came in and was going to assist me with transferring her to her wheelchair. I was holding onto R7's knees because she was extremely contracted, and she was on her back. R7 had her right arm above her head, and she was holding onto the side rail. While V34 had her back turned putting on gloves. R7 then reached and pulled herself with the left arm onto the opposite side rail very quickly and then we heard a pop. V25 was asked again to explain how this happened. V25 stated that it happened very quickly. He stated that he was not sure and his explanation of what happened changed multiple times. V25 was questioned about his written statement and why his written statement did not match his

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explanation of events. V25 became very nervous, began sweating, stating he was beginning to have a panic attack, because the event was just so horrible, he is having PTSD (post-traumatic stress disorder) flash backs. V25 then stated that he was told to lie on his written statement of events because everyone knew that he transferred her using a dead man lift (a lift where 2 people are used, each put an arm under R7's arm and the knee.) to transfer her. V25 stated that he felt it was much safer for her because with movement she would grab onto anything she could get her hands onto. V25 stated she would grab the mechanical lift straps, one time she got one strap unhooked, she would flip around and almost throw herself out of it. V25 stated that the facility did not want to get him in trouble that is why he was told to lie. V25 stated that she was not hurt during transfer because they had not started the transfer yet because he was waiting for V34. During this conversation, V25 continued to be upset, exhibit shallow breathing, sweating and turning red. The interview was stopped to get V25 assistance for his panic attack. After the interview, it still remained unclear as to exactly what happened to R7 because R25's recollection of events kept changing.

On 5/14/24 at 6:00 PM, V34 CNA stated, "Before supper I was helping (V25) get R7 ready for supper. She always grabs the side rail. She was on her back. She puts her arm through the side rail but we were getting ready to sit her up so we could transfer her. V25 had (R7) up to about a 30-to-40-degree angle. She wasn't all the way up yet. I was at the foot of the bed. I looked down for a second. I was fixing my pants or my shoe. I then heard a pop. I guess she threw her arm in there and moved and then it popped. I did not have my back turned. I was not putting on gloves.

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(R7) always uses the dead man carry lift to transfer. She is just unsafe for the full mechanical lift. She moved around so much, and she would grab onto anything. I was told that Physical Therapy made her a dead man lift."

On 5/14/24 at 2:50 PM, V14, Director of Nurses, stated, "(V25 and V34) told me they were changing (R7), and she got a hold of the side rail and then she rolled, and the arm popped. (R7) was a (full mechanical lift) with 2 people. I never heard they were dead man lifting her. I would not be ok with that."

On 5/17/24 at 9:59AM V14, Director of Nursing stated she wasn't here when R7's fractured arm occurred. V14 stated she was told that R7 was in bed and two staff members were changing R7 and when they went to turn R7, they heard a pop. V14 stated R7 was known to grab rails even when she was sleeping and had a death grip on the side rails. V14 stated she guessed there was risk of R7 having side rails with her grabbing them and not letting go was injury or entrapment. V14 stated she was unaware that V25, CNA was told to lie on the incident report. V14 stated she expects the risk versus benefits to be assessed and documented.

On 5/21/24 at 9:20AM, V1, Administrator stated she did not interview anyone else for R7's investigation and she "probably should have". V1 stated she just believed what staff said.

On 5/13/24 at 10:25 AM, V14, Director of Nurses, stated R7 was 100 years old, total care and had been that way for a while. V14 was questioned if she knew R7's admitting diagnosis for hospice since she was recently admitted to hospice and past on 5/8/24, V14 stated, "I don't know but

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since the break she just went downhill."

On 5/13/24 at 3:00 PM, V18, Registered Nurse (RN), stated, "(R7) was total care and dependent on staff. I was here when her arm was broken. The CNA came running to me stating "Weneed you. We think her arm is broken." She was lying on her left side. It was evident that her arm was broken. They told me that it happened while getting her up. She had a habit of wrapping her arms around the side rail. I think it was for security. I think her arm was caught in the side rail. I called her family and 911 immediately to get her to the hospital. I honestly can't say if her fracture exacerbated her death."

On 5/14/24 at 9:10 AM, V2, RN, stated, "I have never known (R7) to wrap her arms around the side rails. She would grab onto them. I think the CNAs might have gotten too forceful in removing her hand or it happened while turning her in bed. Ever since I have worked there, (R7) has always been picked up by 2 staff on each side of her. She was very light and contracted. A (mechanical lift) has never been used on her. I think a lift would have been more dangerous because the way she grabbed, flipped, and her contractures. R7 had been stable for the past 6 months. She came back from the hospital with pain. It was very painful for her. She did have Norco for the pain which helped. She very quickly declined, went on hospice, and passed away. I was afraid we would not get her on hospice fast enough to even help her."

On 5/15/24 at 5:15 PM, V2 stated that R7 had 1/4 side rails when the fracture happened, and the side rails remained on her bed after her return. V2 stated that when R7 returned from the hospital she was in a lot of pain.

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On 5/16/24 11:25AM V39, Certified Nurse Assistant (CNA) stated she cared for R7 and knew her well. V39 stated R7 has always had side rails on her bed and is not aware of any alternative to the side rails that have been tried. V39 stated she put mesh padding on side rails once by herself because R7 always had a death grip on side rails, but R7 was still able to get through to grab the side rails so it didn't last long. V39 stated R7 always found her way to grab the side rails. V39 stated because R7 had a death grip on the side rails you needed to verbally cue her multiple times, take your time with her. V39 stated she felt R7 was scared with rolling and that's why she always was hanging on side rails. V39 stated everyone in the building except one resident has side rails. V39 stated there has been no other interventions put in place prior to side rail use.

On 5/16/24 at 11:40AM, V18, Registered Nurse stated she cared for R7 routinely and the side rails have been on her bed as long as I can remember, and she has worked here for years. V18 stated there have been no alternative to side rail that was attempted that she is aware of. V18 stated R7 rolled around on her. V18 stated R7 was always hanging on the bedrail all the time. When asked if R7 was at risk for entrapment in the side rail, V18 stated she guessed it could happen to anybody- then stating, "I'm sure that could happen."

On 5/16/24 at 1:37PM, V28, CNA stated R7 had side rails up the whole time she was here and had a firm grip. V28 stated R7 was a 2 person Hoyer lift. V28 stated there were no alternatives to help turn and reposition R7 but that covers were put on and didn't help, R7 found her way

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around them to grab side rails.

On 5/17/24 at 10:19AM, V1, Administrator stated R7 was being provided care from V25, CNA and when they rolled R7, V25 was cradling R7 and R7's arm was over V25's head and they heard a pop and R7 's arms had been caught in the side rails while positioning her. V1 stated R7 used the side rail and "held on for dear life" and that staff would sometimes have to pry R7's hands off the siderail. V1 stated knowing R7's history, staff should put a pillow or something to prevent R7 from grabbing side rails during care, or in a perfect world, put the side rail down while providing care. V1 stated she was not aware that V25 told the survey team that he was instructed to lie about his written statement and what happened with R7 and that they "should know better than that."V1 stated there are known risk associated with side rails use such as entrapment and the facility is only approved for quarter rails and V1 expects assessments for side rails to be accurately and completely filled out. V1 further stated she expects staff to intervene when a resident arms or legs are in a siderail.

On 5/15/24 at 10:38 AM, V1, Administrator, stated that R7 does not have a Side Rail Assessment and has never had a Side Rail Assessment completed. V1 further stated that a resident should have a Side Rail Assessment upon Admission and then quarterly.

2. R10's undated Face sheet documents R10 was admitted on 4/08/2022 with a diagnoses dementia with other behavioral disturbances- with hallucinations polyosteoarthritis, age related physical debility, history of fall, mixed receptive-expressive language disorder.

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R10's Physician Order Report dated 4/21/2024-5/13/2024 does not document an order for side rails.

R10's Progress Notes dated 3/1/24 at 1:50PM documents R10's medical doctor notified of increased agitation/hallucinations during the evening ad night. R10 noted to scream that someone is in her room trying to kill her and take her things. Noted to throw things in her room. Comes out to hall yelling for help to get them out of her room.

R10's Minimum Data Set dated 3/18/24 documents R10 has short- and long-term memory problems, Brief Interview for Mental Status was unable to be completed, moderately impaired decision making, and the ability to understand others is coded a 2: sometimes understands. The MDS documents R10 has behavior symptoms directed towards others and that R10's current behavior status as a two (2): worse. The MDS further documents R10 uses a walker and wheelchair with no impairment to upper extremities and impairment on both sides of lower extremities and is independent with rolling left and right in bed.

R10's Care Plan dated 3/28/24 documents to keep environment free of clutter and obstacles to reduce risk of injury with a start date of 4/30/24. R10's Care Plan further documents behaviors symptoms: resident exhibiting problems as seen by making disruptive sounds, hallucinations and delusion, pressure ulcer/injury: ensure proper body alignment when in bed or chair to reduce pressure, activity of daily living function status: start date 10/12/22 siderails: 1/4 rails up as per doctors' orders for safety during care provision to assist with bed mobility. Observe for injury or

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entrapment related to side rail use. I need to have 1/4 siderails x2 up to assist me with getting around my bed.

R10's Most recent Side Rail Assessment dated 1/14/24 documents type of side rails indicated: "both" to allow for increased bed mobility, safety risk with use of side rails "none". There is no side rail assessment for the quarterly 4/2/24 reporting period.

On 5/16/24 at 1:45PM, R10's door was shut. Upon entry with V28, CNA, and V39, CNA, R10 was observed to be laying in her bed and her right arm was through the right-side rail. R10's body was adjacent to the side rail and the side rail was all the way up to R10's shoulder. R10 began moving and extending her right arm to point at an object in her room though the side rail. V28 stated they keep R10's door shut all the time because she hallucinates and yells out. R10 stated she didn't have lunch and that people were trying to kill her. V28 went and got R10 ice cream and redirected R10 multiple times to move her (R10's) arm through the side rail to hold the ice cream.

On 5/17/24 at 7:53AM, R10 was in her bed with her right arm through the side rail up to her shoulder eating breakfast with her right hand. R10 requested staff assistance and this surveyor went to get V2, Registered Nurse. V2 checked on R10 and R10 was confused about where her stuff was. When asked if R10 was normally positioned with her right hand through the side rail, V2 stated that he had seen R10 like that before. V2 stated the side rails would be a risk for R10 due to her cognition and psychiatry/behavior history and that any object is a risk to her, stating R10 has pulled all the baseboards off, and it wouldn't surprise me if she had a drawer pulled apart even. During this

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time, it was noted R10's baseboards were gone.

On 5/16/24 at 3:10PM R10's side rails were measured at 17 3/4 inches wide and 3 1/2 inch tall, and the bottom portion as 22 3/4 inch wide and the top 3 1/2 inch wide.

On 5/17/2024 9:46AM V40, Assistant Director of Nursing stated she just took this position and started 5/13/24. V40 stated every occupied bed in facility has siderails and thinks they are ¾ rails. V40 stated risk of having side rails could be getting stuck in between, ones that can't or are not independent, and that limbs and head can get stuck. V40 stated she is not aware of alternatives to the side rails due to just starting.

On 5/17/24 at 9:59AM V14, Director of Nursing she expects the risk versus benefits to be assessed and documented. V14 stated she came from the hospital, so she didn't realize you needed an assessment for side rails. V14 stated R10 has a lot of psych issues and is schizophrenic and she expects staff to move R10's or any residents arm out of the side rail if they saw that. V14 further stated R10 can get agitated but she expected staff to redirect R10 and assist R10 to scoot over in bed away from side rail.

On 5/17/24 at 10:19AM, V1 Administrator stated there are known risk associated with side rails use such as entrapment and the facility is only approved for quarter rails and V1 expects assessments for side rails to be accurately and completely filled out. V1 further stated she expects staff to intervene when a resident arms or legs are in a siderail. V1 stated R10 does whatever she wants and sometimes it is hard to redirect her, but she still expects staff to ensure

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she is safe. V1 state the side rails are a risk to R10.

On 5/21/24 at 3:45PM, V1 stated the facility reassessed R10 for side rails use and according to their assessment R10 should have never had side rails on to begin with.

On 5/16/24 at 9:30 AM, V1, stated that she is unable to locate a side rail policy. V1 stated, "I have had 4 people working on it since yesterday afternoon and they still cannot locate one."

On 5/17/2024 9:35AM V1 was asked again if the facility had a side rail policy and V1 stated they do not have a policy on siderails.

3). R6's Resident Face Sheet, undated, documents that R6 was admitted on 2/29/24 with diagnoses of Dementia with Anxiety and Weakness of the Left Side.

R6's Minimum Data Set, dated 5/3/24, documents that R6 is severely cognitively impaired, is dependent on staff for all mobility, activities of daily living, does not ambulate and does not have a pressure ulcer.

On 5/15/24 at 9:00 AM, V4 Certified Nurses Aide (CNA), stated that on 5/1/24 she transferred R6 to bed by herself and did not hit R6's leg on the side rail.

On 5/16/24 at 9:30 AM, V1, Administrator, stated that R6 did have 1/4 side rails on before she went to the hospital, R6 did not have a Side Rail Assessment before the side rails were place, R6 does not move in bed, and the family wanted the side rails on the bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009369	A. BUILDING: _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAYLORVILLE CARE CENTER	600 SOUTH HOUSTON TAYLORVILLE, IL 62568

(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
S9999	Continued From page 49 R6's Side Rail Use and Risk Assessment, dated 5/7/24, documents that R6 has bilateral 1/4 length side rails. Reason for Use: Resident or Legal Representative request for side rails. Purpose of side rail(s) being used for a resident who is immobile and can not voluntary get out of bed because of physical limitations. Unmarked. Resident has medical symptom(s) contributing to use of side rail(s) Unmarked. Resident factors impacting side rail use: Requires assist with transfers. Select other methods used besides side rails: None of the bed. Resident / Family/ Resident Representative Information Consent Information: Risk factors is not checked. (B)	S9999		