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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1210a) 300.1210b) 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. Based on interview and record review, the facility failed to prevent a resident's fall from the bed to the floor, who was assessed as a two person assist for bed mobility. This failure affected 1 (R44) of 28 residents reviewed for falls. R44 was emergently transferred to the hospital with increased pain and experiences psychosocial harm, feeling scared and afraid while being turned in bed by staff. Section 300.1210 General Requirements for Nursing and Personal Care	S9999		

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S9999	Continued From page 1 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. 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.	S9999		

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These regulations were not met as evidenced by:

Based on interview and record review, the facility failed to prevent a resident's fall from the bed to the floor, who was assessed as a two person assist for bed mobility. This failure affected 1 (R44) of 28 residents reviewed for falls. R44 was emergently transferred to the hospital with increased pain and experiences psychosocial harm, feeling scared and afraid while being turned in bed by staff.

Findings include:

On 5/20/24 at 11:13am, R44 stated that R44 has been in the facility for almost 2 years, and "I (R44) don't walk." R44 stated, "I fell out of bed about 2 months ago. I had moved to (another floor) because they needed my room as an isolation room." R44 stated that in R44's current room, R44's bed is up against the wall and that the room on the other floor (where R44 had been temporarily transferred on 2/13/24) didn't have a wall next to R44's bed, so R44's bed was open on both sides. R44 stated, "(V20 Certified Nursing Assistant/CNA) was on the same (one) side and pushed me over to change me. I was holding onto the end table. When (V20) pushed my (incontinence brief), (V20) pushed it under my buttock, and I fell face first on the floor. I had bruises on my right knee and feet and my toes and elbow hurt. There was no side rail." When asked if one or two CNAs assisted R44 with turning in bed for incontinence or activities of daily living (ADL) care, R44 stated that there was one CNA, but now, a majority of the time, there's 2 people." When asked if the staff move the bed away from the wall to stand on one side (with other CNA on the other side), R44 stated, "No. I

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roll to the side and hang onto the wall. My body hits against the wall to keep me propped up." R44 said that both CNAs stay on the one side for R44's care. R44 stated, "I am not over it. I still have issues of getting too close to the side." When asked how does this make R44 feel, R44 stated, "I feel afraid on the inside. I talked to my psychiatrist (V24) about it." R44 said that R44 even asked V24 if it was R44's fault that R44 fell, and V24 said, "You have nothing to do with it. It's not your fault. They had one aide there. It was their mistake." R44 stated that V24 said to get it out of R44's head and to not think about it. R44 stated that R44 talked to V24 shortly after the fall happened on 2/23/24 with V2 (Director of Nursing/DON).

On 5/22/24 at 9:38 am, R44 was reinterviewed and stated that it was at 8:30pm on 2/23/24 when R44 fell from the bed to the floor. When asked if R44 has expressed R44's feelings after R44's fall, R44 stated, "I told (V2), and I had talked to (V24) after I had fallen. I still have a phobia to falling off the side of my bed." R44 stated, "(V2) was in the room with (V24) when I said that I am scared about rolling off the bed. I told (V2) the other day too." R44 stated that before this fall on 2/23/24, "I have never fallen before." When asked about a fall mat as a fall precaution, R44 stated that there was one in the room but that there was problem with the bedside table not rolling on it. R44 stated, "I rely on that table. I tried it, and it wouldn't roll at all." R44 stated, "since I am larger, it's harder for me to move in bed. I can't move my legs. I have so much pain." R44 stated, "I can pull with my arms. They had even talked about a trapeze, but that didn't come to be."

R44's Face Sheet documents, in part, diagnoses of idiopathic peripheral autonomic neuropathy;

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chronic obstructive pulmonary disease with (acute) exacerbation; asthma, uncomplicated; acute embolism and thrombosis of other specified deep vein of right lower extremity; pain in left leg; anxiety disorder due to known physiological condition; arthropathy; obesity; essential (primary) hypertension; heart failure, unspecified; cramp and spasm; hypoparathyroidism; localized edema; major depressive disorder; hyperlipidemia; presence of left artificial knee joint; non-pressure chronic ulcer of unspecified part of left lower leg limited to breakdown of skin; body mass index [BMI] 34.0-34.9, adult; and bacterial pneumonia.

R44's Minimum Data Set (MDS), dated 4/17/24, documents, in part, a Brief Interview of Mental Status (BIMS) score of 15 which indicates that R44 is cognitively intact. R44's bed mobility of rolling left and right is indicated as substantial/maximal assistance. R44's MDS, dated 1/19/24 and 4/17/24, indicate no side rails in use.

R44's Care Plan, active effective date of 1/13/24, documents, in part, a focus of "(R44) is at risk for falls related to impaired mobility, pain on right lower extremity, unable to stand without staff assistance, use of psychotropic medication" with a goal of R44 being free from falls until next review and interventions of "anticipate resident needs in relation to present ADL function" and "provide education on safety techniques."

R44's Fall Risk Assessment, dated 1/12/24, documents, in part, a score of 10 which is a high fall risk.

R44's Census Activity, documents, in part, that R44 was transferred to another room on another

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floor on 2/13/24.

On 5/22/24 at 2:43pm, V20 (CNA) stated that R44 is alert, and "(R44) is bed bound." When asked about R44's fall incident on 2/23/24, V20 stated that V20 was taking care of R44 in R44's new room on the 3:00pm to 11:00pm shift, and it was about 8:30pm. V20 stated, "I (V20) was changing (R44's) (incontinence brief), cleaning (R44) on the bed. There's no bed rail. (R44's) bed was not against the wall. I turned (R44) by myself. (R44) usually holds onto the side of the bed frame with (R44's) hand on that side. I was just ready to bring (R44) back to me when I realized that (R44) fell. I hollered help. No one came. I had to come out the room. I said to (V27, Security), 'Please call the nurse (V18, Registered Nurse/RN). I need help'." V20 stated that V18 then came into R44's room, assessed R44, and then 911 emergency services were called. When asking V20 about what action in R44's care was V20 performing when R44 fell off the bed, V20 stated, "I was putting (incontinence brief) on (R44). I (V20) had rolled (R44) away from me. I was behind (R44), and I pull (R44) back to put clean (incontinence brief) under (R44's) hip. I just slid it (clean incontinence brief) under hips, and R44 fall out of bed." When asked how high the bed was during R44's care on 2/23/24 at 8:30pm, V20 stated that V20 had raised to the height of R44's bed to about V20's waist for V20 to provide R44's care. When asked if R44 was in the middle of the bed when turning R44, V20 said that V20 usually makes sure that residents are in the middle but didn't with R44. V20 stated that R44 landed on the floor, and "I run around the bed and look at (R44) on the floor. That's the first thing I did, run around and see (R44). Then I hollered for help. No one. Then I run out by the room door and holler to (V27) to send in (V18)." V20 stated

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that after V18 responded, V18 informed V20 that two staff members usually turn R44 in bed. V20 stated that V20 told V18, "I never had a problem with (R44) before, but (R44) was in a room with bed against the wall. This bed was open on both sides. I didn't think something like this was going to happen. Can (R44) have a bed rail? I cared for (R44) before with one person. Bed was against the wall, I did it before." When asked, how does V20 know how many staff persons it takes to assist residents with bed mobility, V20 stated, "I look at their size. I had been able to do (R44) with one before, but I know now that I need two. If it's a large person, common sense tells you, you need two." When asked if V20 looks in the chart for assistance level, V20 stated yes, but couldn't tell where to this surveyor. On 2/23/24, V20 was asked if R44 needed two staff persons for assistance with turning, V20 stated, "At that time, no." "Not need two people." (sic) When asked if R44 moves R44's legs in bed, (V20 shaking V20's head no) and stated, "(R44) does not move (R44) legs."

On 5/21/24 at 2:19pm, V18 (RN) stated that R44 is alert, oriented, stays in the bed and is "almost bed bound." When asked about R44's fall incident on 2/23/24, V18 stated that V18 was made aware of R44's fall when V20 (CNA) came to V18 and said that R44's on the floor. V18 stated that V18 went to the room, and R44 was laying, face down on the floor and that R44 said R44 fell when V20 was taking care of R44. When asked if V18 had performed incontinence care with R44 prior to the fall on 2/23/24, V18 stated that V18 had an admission that day. V18 stated that when R44 fell, "I (V18) called 911. (R44) is very big (weight). There was one CNA (V20) on the floor. (V20) was elderly. (R44) stayed on the floor." When asked about R44's position, V18

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stated that R44's bed was open on both side with no side rails, and R44's position on floor was face first. V18 stated that R44's body on the floor was parallel with the bed and was in between the wall and nightstand (end table) where there was a wall near R44's head. V18 stated that R44 was alert and said that R44 bumped R44's head on the wall. When asked if R44 complained of pain after the fall on 2/23/24 at 8:30pm, V18 stated, "Yes, (R44) had pain. I gave (R44) pain meds a few hours before the fall. I gave (R44) all (R44's) meds." When asked about where R44 was complaining of pain, V18 stated, "(R44) didn't talk much due to position (laying face down on floor). I just moved (R44's) head to put pillow and and use sheet to cover (R44). (R44) was naked." V18 stated that "(R44) did have redness to right side of R44's face." V18 stated that V18 did not medicate R44 with any pain medication due to already giving R44's pain medication prior to R44's fall. V18 stated that when V18 gave R44 the medications before R44's fall, R44's bed was in the low position; however, when V18 went in with V20 (CNA) after the fall, "(R44's) bed was high. (V20) was taking care of (R44)."

In R44's Progress Note, dated 2/23/24 at 9:09pm, V18 (RN) documents, in part, "At 8:40pm, writer was informed by (V20, CNA) that resident fell off the bed while giving care. Writer immediately went to resident room and found (R44) on the floor facing down, initials assessment done, noted with redness on right-side of the face, no bleeding noted, voiced 5/10 on pain scale, resident states 'I hit my head on the wall'."
R44's February 2024 MAR (Medication Administration Record) shows that on 2/23/24 from 3:00pm to 11:00pm, there is no documentation of Hydrocodone 5 milligram (mg)/Acetaminophen 325 mg tablet oral every 6

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hours PRN (whenever needed) was noted.

Facility document, titled "CNA Assignment Sheet" and dated 2/23/24 for 3:00pm to 11:00pm shift (on R44's new floor from transfer date of 2/13/24), documents, in part, that V18 is the nurse assigned, and V20 is the one CNA assigned to the floor.

R44's emergency hospital records, dated 2/23/24, document, in part, that R44 was being "changed at the nursing home and fell off of the bed. (R44) with head strike and pain to right arm, bilateral feet," and that R44's pain to right arm and bilateral ankles is "exacerbated from baseline."

On 5/22/24 at 10:16am, V4 (Restorative Nurse, Licensed Practical Nurse/LPN) stated that R44 was receiving bed mobility for restorative therapy because R44 had reached R44's "maximum potential with transfers" in skilled therapy. V22 stated that with standing, "(R44) could not do it. (R44) can't with left leg." When asked about bed mobility for R44, V4 stated that it's "how (R44) can maneuver left to right in bed and repositioning." V4 stated that it's done with the CNA staff and also with the restorative aide (V5). When asked what R44's bed mobility staff assistance level for turning left to right in bed is, V4 stated, "Substantial maximum assist with 2 persons. It needs to be 2 persons. It's for safety purposes. (R44) has no side rails. One person is on one side of the bed and the other person is on the other side of the bed to avoid falls." When asked how this is done when one side of R44's bed is up against the wall, V4 stated that the aides will move the bed from the wall, so that one person is on one side and the other person is on the opposite side. When asked about side rails as an option for R44, V4 stated that "it's our facility

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S9999	Continued From page 9 policy of no side rails. We don't have side rails." V4 stated, "That's why at all times for R44's changes (incontinence care), it has to be 2 persons." When asked about R44's fall on 2/23/24, V4 stated, "(V20) tried doing (R44's) care alone. It caused the fall. There was no other CNA on the floor. That was the problem." When this surveyor informed V4 that R44 stated R44 is utilizing the end table next to R44's bed for support when there is one CNA turning R44 in bed, V4 stated, "That's not acceptable. (R44) should not be holding that. There should be someone there. The nightstand is used for (R44's) personal things." V4 stated, "(R44) has pain all the time with legs" causing decreased mobility in bed which is why R44 is a two person assist for bed mobility. R44's Restorative Program Notes, dated 1/15/24, documents, in part, that R44 is receiving bed mobility restorative therapy with "(R44) is working towards set bed mobility goal of turning onto left side with substantial maximal assist from staff, goal ongoing" and that R44 has "presence of left artificial knee joint, weakness, other lack of coordination and pain in left leg, and has decreased ROM (range of motion) to BLE (bilateral lower extremity)." R44's Restorative Functional Assessment, dated 1/17/24, documents, in part, that R44 was "noted with decreased bed mobility skills, total to substantial maximal assist from staff was provided to resident when performing bed mobility maneuvering and repositioning" and that R44 is "non-ambulatory/wheelchair/bedbound." On 5/22/24 at 11:20am, V2 (DON) stated that V2 was notified by V18 (RN) on 2/23/24 about R44's fall. When asked if V2 inquired about details of	S9999		

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the fall incident, V2 stated, "I (V2) asked what happened and (V18) said that (V2) was repositioning (R44) and (R44) fell. I (V2) asked (V18) if (V20) asked (V18) for help because (R44) is a two person assist. (V18) said no." When asked about R44's fall on 2/23/24, V2 stated that "(R44) had never fallen before," and that since R44 had surgery on left leg with a pin inserted, R44 cannot bend the left knee. V2 stated that R44 has received multiple skilled therapy sessions to strengthen R44's legs, but R44 has reached the maximum potential. V2 stated that R44 sees V24 (Psychiatrist) for depression. When asked if V2 was with V24 (Psychiatrist) on 3/7/24, when V24 was talking to R44 after the fall on 2/23/24, "Yes, I did rounds with (V24) after the fall. (R44) said that (R44) was scared and apprehensive with (staff) turning her. I assured (R44) that we will make sure proper staff" provide R44's care. When asked if V2 has spoken to R44 about still feeling scared with receiving care in bed, V2 said that V2 hasn't and will make sure that V2 supervises R44's care. V2 stated, "I understand that (R44's) kind of scared but will have to overcome that gradually." V2 stated that two persons are there during care so R44 should not have that feeling of being scared. This surveyor informed V2 that R44 said that when staff turn R44 now, R44 uses the wall as a support device, and V2 stated, "That should never be. That's inappropriate. It should be two persons." V2 stated, "It's never appropriate to use the wall like that. It should never happen." V2 stated, "(R44's) care planned for two people to assist." When asked if using two persons for turning R44 in bed is ensuring that R44 is feeling safe and not scared, V2 stated, "Yes."

On 5/23/24 at 4:46pm, V24 (Psychiatrist) stated that V24 sees R44 in the facility for depression

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and anxiety. This surveyor explained to V24 about the review of R44's fall incident on 2/23/24 in the facility. When asked if R44 and V24 had a conversation about R44's fall after it occurred, "Yes." V24 stated, "It was the caregiver (V20) turning (R44) too fast or positioning. I provided (R44) more comfort. I told (R44) not to feel anxious about this one caregiver (V20) and try not to generalize it to all staff." When asked if R44 stated to V24 that R44 was still feeling afraid and scared after the fall when R44 is having care rendered by staff, V24 stated, "Correct." V24 stated that R44 has a fear of falling from this fall incident on 2/23/24. When asked if V24 has visited R44 since having this conversation, V24 stated that V24 couldn't recall but doesn't think so.

In R44's Progress Notes, dated 3/14/23 at 9:03pm, V24 documents, in part, that R44's last date seen was 3/7/24.

Facility policy (undated) titled "Fall Prevention Policy" documents, in part, "It is the policy of (Facility) to identify residents at risk for falls and to implement a fall prevention approach to reduce the risk of falls and possible injury... Every resident will be evaluated for falls upon admission and subsequently thereafter when the resident's condition changes or at least quarterly. The care plan will state the goals, interventions and approaches to every resident who was identified as being at risk for falls. Staff will be trained to be alert to risk and hazards for falls in the environment."

Facility policy (undated) titled "Facility Policy Regarding Resident Falls" documents, in part, "Overview: This facility is committed to minimizing resident falls so as to maximize each resident's

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physical, mental and psychosocial well-being. While preventing all resident falls is not possible, it is this facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventative strategies, and facilitate as safe an environment as possible."

Facility policy (undated) titled "Personal Care Services" documents, in part, "Policy: Each resident shall receive nursing care and supervision based on individual needs. Each resident shall show evidence of good personal hygiene. A patient care plan for each resident is developed based on the nature of the illness, treatment prescribed, long and short term goals, and other pertinent information. The nursing care plan is a personalized plan of care for individual residents. It indicates what nursing care is needed, how it can be accomplished for each resident, how the resident likes things done, what methods and approaches are most Successful; and what modifications are necessary t (to) insure (ensure) best results. Nursing care plans are available to all nursing personnel assigned to a resident. Procedure: ... Incontinent residents: Incontinent residents shall have partial baths and clean linen each time the bed or clothing is soiled."

Facility job description, dated May 2003 and titled "Certified Nursing Assistant," documents, in part, "Purpose of the Position: The primary purpose of the position is to provide your assigned residents with routine daily nursing care in accordance with our established nursing care procedures, and as may be directed by your supervisors. Duties and Responsibilities: ... Nursing Care Functions: ... 25. Perform ADL programming in accordance with each resident's individual care plan goal ... Safety and Sanitation: ... 8. Follow established

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safety precautions in the performance of all duties."
(B)
Statement of Licensure Violations (2 of 2)

300.4090c)5)

Section 300.4090 Personnel for Providing Services to Persons with Serious Mental Illness for Facilities Subject to Subpart S:

c) Psychiatric Rehabilitation Services Coordinator

5) There shall be a PRSC for each 30 participants.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to have a Psychiatric Rehabilitation Services Coordinator/PRSC to meet the individualized psychosocial and mental health needs of residents.
This failure has the potential to affect all 68 residents with diagnoses of Severe Mental Illness and other residents in the facility who require psychosocial support.

Findings include:

On 5/20/24 at 10:15am after the entrance conference, V1 (Administrator) presented the facility census as 96 residents. On 5/21/23 at 2:20pm, V21(RN/Registered Nurse/Care Plan Nurse) presented the list of 68 residents with severe mental illness (SMI) and stated, "We have a total of 68 SMI residents".

On 5/20/24 between 10:30am and 12:00pm, several residents including R65, R79, R86, R88,

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and R195, were observed just sitting in the room with flat affect and low mood.

On 5/21/24 at 10:44am, both R86 and R88 (roommates) were observed sitting in their beds doing nothing. The surveyor asked both residents about receiving the services of a counselor or PRSC or therapist. R88 stated "I have not seen any counselor or therapist since I came here. I've been here for 4 months." R86 stated "No one cares to know how you're feeling." Also, R65, R79, and R195 denied seeing or talking with a counselor/PRSC recently.

On 5/21/24 at 11:55am, V10 (Licensed Practical Nurse/LPN) and V11 (CNA/Certified Nurse Assistant) were observed and interviewed on the nursing units regarding the availability of social services staff to speak with residents individually. V10 stated that V16 (Social Services Director/PRSD - Psychiatric Rehabilitation Services Director), is the Social Worker for all the residents. On 5/21/24 between 10:20am and 12:00pm, no PRSC was observed on the nursing units to interact with the residents.

On 5/21/24 at 10:22am, V16 (Social Services Director/PRSD - Psychiatric Rehabilitation Services Director), was asked to explain how she (V16) was able to provide individualized psychosocial and mental health services to all 96 residents in the facility and especially the 68 residents with diagnoses of SMI. V16 stated that she (V16) recently started work at the facility and she is doing her best with the residents. V16 stated a therapist comes twice a week to do groups for the residents. V16 was asked about what services the PRSC is supposed to provide for residents if a PRSC is hired. V16 stated "Assessments, groups, and sometimes 1:1 as

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needed."

On 5/21/24 at 11:25am, the surveyor called V1 (Administrator) to express the concern that only V16 (PRSD/Social Services Director) is responsible for providing psychosocial services for 96 residents, including those with diagnoses of severe mental illness. V1 stated that they had advertised the positions and made efforts to hire more people to meet the needs of the residents. The surveyor inquired from V1 how many PRSCs the facility is trying to hire. V1 stated that they need one full time PRSC and one part-time PRSC.

Facility's document dated 1/1/2015 titled "Job Description" of the Psychiatric Rehabilitation Service Coordinator (PRSC) states "The primary purpose of your job position is to assist in planning, developing, organizing, implementing, evaluating, and directing social service programs in accordance with current existing federal, state, and local standards, as well as our established policies and procedures, to assure that the medically related emotional and social needs of the residents are met/maintained on an individual basis."

Facility's Policy on "Psychosocial Programming", under Policy Statement states: The purpose of this Psychosocial program is to assist each resident in meeting his or her psychosocial needs and learning to cope successfully with his or her disability and adjusting to life in the facility. The program is based on the principles of sequential skill development. The program is carried out under the coordination of the PRSC. #1: Identify the resident's functional skills in the areas of self-care, social skills, community living skills, and vocational skills. In addition, identify physical,

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S9999	Continued From page 16 cognitive, communication, psychosocial, mood, and behavior problems that impair functioning. Facility's "Facility-Wide Assessment" document Part 2 states in part: Services hand care we offer based on our residence needs. Find below the types of care that our resident population requires and that we provide for our resident population: Mental Health and Behavior - Manage the medical conditions and medication related issues causing psychiatric symptoms and behavior. Identify and implement interventions to help support individuals with issues such as dealing with anxiety, individuals with depression, care of individuals with trauma, care of individuals with other psychiatric diagnosis etc. (etcetera) (C)	S9999		