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	IL6008874	A. BUILDING: _____ B. WING _____	C 06/30/2024

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S 000	Initial Comments Invesitigation of Facility Reported Incident of 5/29/2024/IL174313	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.610c)4)A)D)F) 300.1210d)6) 300.3210t) 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. c) The written policies shall include, at a minimum the following provisions: 4) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following:	S9999		

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S9999	Continued From page 1 A) Analysis of the risk of injury to residents and nurses and other health care workers taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs; D) Restriction, to the extent feasible with existing equipment and aids, of manual resident handling or movement of all or most of a resident's weight, except for emergency, life-threatening, or otherwise exceptional circumstances; F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident Section 300.1210 General Requirements for Nursing and Personal Care 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 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or	S9999		

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misappropriation of property.

These requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to protect a residents' right to be free from verbal, physical and mental abuse by an employee. This failure affected one (R1) of four residents in the sample reviewed for abuse. This failure resulted in R1 feeling unhappy, fearful, and not wanting to have her daughter leave her alone at the facility. The facility also failed to safely transfer a resident (R1) using a mechanical lift and failed to follow the facility procedure for use of a mechanical lift for one (R1) of four residents. The facility failure to follow the mechanical lift transfer safety guidelines resulted in injury to R1 who sustained bruises during a one-person staff transfer.

Findings include:

R1's diagnosis includes: Anemia, unspecified, Hypothyroidism, unspecified, Type 2 diabetes mellitus without complications Hyperlipidemia, unspecified, Essential (primary) hypertension Athscl heart disease of native coronary artery w/o Cardiomyopathy, unspecified Acute respiratory failure with hypoxia, Gastritis osteoarthritis, unspecified site Muscle weakness (generalized).

R1's MDS Dated 5/20/2024 BIMS - 15 (indicating cognitively intact)

Facility's reportable to state agency regarding R1 documents in part: The resident was admitted on May 14th, 2024 with the above diagnoses. The writer and administrator was notified by the nursing staff that the resident complained of

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inappropriate behavior from her night CNA staff, V12 (CNA). She (R1) claims the CNA (V12) grabbed her arm and aggressively lifted her, pulled the oxygen tubing out of her nose, and threw her in the shower. It was also claimed this CNA (V12) tried to make the resident (R1) stand when she was unable. The shower happened approximately at 6:40AM. A body check was performed with extensive new bruising found to the upper right forearm and underneath her right breast. The CNA was suspended pending investigation and police were called. Investigation started immediately. Police arrived and were informed of the suspicions regarding physical harm to the resident. Information was provided to the officer as requested which included pictures. Police investigation was conducted which included an interview between the officer and resident, in the presence of the executive director and director of nursing. The resident's statements were similar to those made upon initial interview with the administrator. Resident said "she was rough and she grabbed my arm. She threw my oxygen on the ground. She barely showered me." A large area of bruising to the right upper arm was confirmed with pictures and measurements. The POA and daughter (V17) voiced "my mom was scared and upset. And her arm is all bruised and she didn't have that before." New bruising was also found underneath the right breast. Upon review, it was determined a lift was not performed properly, as indicated by the resident. The resident said "she kept pulling at me and it hurt. I (R1) asked her (V12) to stop and she wouldn't." Pictures were taken of all the new bruising, measured and confirmed to be new by the POA, clinical staff, and resident. When interviewed, the CNA (V12) denied all allegations and claimed the resident (R1): "was screaming all night." She (V12) gave no indication that she was aware of

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harm caused to the resident and was unresponsive to questions asked regarding the matter. A trauma assessment was completed on R1 who expressed some negative emotional effects as a result of the incident. Conclusion and result: The CNA, V12 was immediately terminated from her position within the facility based on substantial evidence of harm to the resident. She was not allowed or present within the building following the allegations to keep all residents free of harm. The resident and family chose to press charges and police investigation began. Care plan was updated to reflect new injuries and emotional harm to the resident.

R1's care plan dated 5/29/2024 documents in part: Problem/Need: Problem Onset: 05/29/2024 Mental distress, Goal & Target Date Show at least one physical sign that stress is being alleviated by 8/1/24, Approaches * Social Services to evaluate and visit* Observe for change in mental status. Document and report any decline to physician * Monitor resident behavior * Approach resident warmly and positively * Encourage verbalization. Listen in non-judgmental manner. * Encourage loved one(s) to visit/telephone * Acknowledge resident's moods in one-to-one interactions.

On 6/28/2024 at 2:10pm Surveyor asked V7 (LPN) if she remembered incident involving R1 on 5/29/2024. V7 stated, yes, the best I can remember. I took care of R1 that morning (5/29/2024, 7a-3p). I finished the morning report and the CNA (V5) that works on the side R1 was on came to me and said R1 was not happy with the night CNA (V12) who worked with her. R1 said, V12 was rough. I (V7) went and checked on R1 and she was up in the wheelchair and R1 told me she (R1) did not want to talk about it but she was not happy with the night CNA. I (V7) called

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V1. I asked resident if she was in pain and she said no, I just don't like the CNA (V12) that took care of me the night (11p-7a) of 5/28/2024 into 5/29/2024. R1 said she was forced to take a shower. R1 seemed agitated and did not want to talk about it so I called V1. She said she was okay with the CNA (V5) that was working with her right then on the day shift (7a-3p). An Assessment was completed by the wound care nurse (V9) who went to check her and did a head-to-toe assessment on resident. Surveyor asked V7 if see saw her bruises. V7 stated, no V9 did her skin assessment on admission and V9 compared if there were changes with her skin. V7 stated, I do not remember seeing any bruises on her before this incident. V1 then came and talked to R1 and they interviewed the CNA (V5) and they called the police. Surveyor asked V7 if V12 has worked since this incident. V7 stated, I only heard that V12 could not come back and I have not seen V12 anymore.

On 6/28/2024 at 2:22pm surveyor asked V10 if she remembered the incident that occurred with R1 on 5/29/2024. V10 (CNA) stated, I (V10) did not take care of R1, but I heard what happened to her and I (V10) went to speak to her. R1 spoke Spanish and I would give R1, her tray and coffee in the morning. So that day May 29, 2024, I (V10) came in and heard that something had happened to a resident. I was passing trays and I noticed while passing R1 her tray she was scared. I asked her if she wanted coffee, and I heard something had happened but I did not know who it was. The nurse notified the Director of Nursing (V2) and police and V1 (Administrator), V2 and V7 was talking to R1. R10 stated, "R1 told me the CNA (V12) that took care of her that night the forced R1 to take a shower at 3:00am in the morning. R1 stated, she was scared and terrified

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that she was being forced to take a shower and V12 scared her. R1 did not want to speak that much until her daughter came. R1 looked like she was really terrified. I told R1 to relax and drink her coffee and soon the police department came, and I think the daughter was here by then. R1 looked very serious and terrified looking eyes wide open, she looked tired, but she did not want to go to sleep". I only heard the name (V12), but I did not know her. I had heard she was rough with resident after this happened. "R1 told me she was trying to pull stuff from her and yanking stuff away from her, but I do not know if she hit her or not, only pulling stuff away from her. R1 was just really nervous. Before this happened, she would talk to me and smile but after this she was a little terrified and did not want to speak". I have not heard anything before or after this incident about abuse, if I do, I will report right away, I do not tolerate that.

On 6/28/2024 at 2:37p V9 (LPN Wound Care Certified) stated, I am familiar with R1 and what happened on 5/29/2024. What happened was the night V12 got her up about 3:00 or 4:00am to take her into the shower room to shower resident. V7 was the morning nurse and mentioned it to me (V9). R1 had a little wound on her buttock, and I was going to do wound care on her buttocks. V7 told me what happened. V9 stated, "I (V9) went to the room R1 was sitting in her wheelchair facing the door and R1 told me she was scared, and she did not want the door closed, so we called her daughter and sat with her. R1 was scared". The daughter came a little later. When the daughter came R1 agreed to be put into bed so I could see if anything was there. So R1 got calmer when her daughter came, and we put her in bed, and I did her wound care and during that time we noted redness like a carpet

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burn that started to turn darker under right breast and arm on the right side. R1 had to be lifted up with the machine, but that is when we noticed that R1 was saying she was pulling something so not sure if the sling was pulled against that area. V9 stated, "When she was admitted R1 did not have those marks. I did the body check when she came in and it was different from a fungal rash or something it looked like it was fresh and just happened". R1 stayed in the chair after this incident, the CNA left her in the wheelchair, and we moved her back to bed. When I got on the floor, I was surprised to see R1 up that early because she usually did not get up until 10am and she had therapy, so it was odd for her to be up that early. We notified the daughter, V1 and police took picture of area. From this the police made report. They called the night CNA (V12) I think V1 or V2 and were following up with her. Prior to this incident, I do not recall anything about this CNA (V12). She was just hired, and she trained for a little bit and she worked alone for one or 2 days then the incident happened. I do not know if anyone else complained. R5 was her roommate at that time. R5 can be confused at times but she can talk. R1's first skin assessment wound on buttocks, bilateral swelling lower leg, and redness in peri area, abdominal fold, inguinal area so we were putting anti-fungal powder on that, but nothing else that I saw. I have not seen V12 anymore since incident.

On 6/28/2024 at 3:05pm survey asked V5 (Agency CNA) if she remembered the incident involving R1 on 5/29/202. V5 stated, yes, I remember R1 she was such a sweet lady. I took care of her that morning R1 was not herself. I remember when she first came to facility she was in pain and had staples in her stomach, but she was getting better. "That morning on 5/29/2024 I

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(V5) came in and checked on her (R1) and she was sitting in her room up in a wheelchair, her hair was wet, and she was leaning in the wheelchair, and she looked very upset. I (V5) asked R1 what was wrong with her. R1 told me that the lady (V12) made her (R1) get up in the middle of the night and made me (R1) take a shower. R1 stated, she was rough with me like man handled R1. R1 was asking for her daughter and said she does not want to be here". I (V5) let the nurse (V7) know right away. V7 came right away and checked on her. The night CNA (V12) was a new African lady that took care of her (R1) that night. The day it happened R1 was so upset that they called the called the police. I (V5) saw the night CNA (V12) on her way out the door that morning, but I did not get to interact with her. "R1 was scared, R1 was shook up". Surveyor asked V5 if she received report from V12 (CNA) V5 stated, V12 did not give me report, they get out of here sometimes before we get here. I remember this incident very well. The nurse that night was V11 (LPN Agency) and I think I recall telling V11 about R1 too. I think when V12 gave R1 the shower V12 was just doing what she had to do. "R1 kept saying I only want my daughter, I want my daughter, she kept saying that and she was not like that before". I had not heard of this CNA (V12) being rough with other residents. I am not sure if she had a roommate. If it was it was R5 she is confused.

On 6/28/2024 at 3:30pm Surveyor asked V11 (LPN Agency) if she took care of R1 on 5/28/2029 into 5/29/2024 11p-7a shift. V11 stated (in part), I remember her from 2west. I (V11) remember the incident that happened. I do not know exactly what happened, but they (V1 and V2) called me in the afternoon and when I woke up, I called them back. They (V1 ad V2) said R1 had some

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bruises on her arm, I do not remember what arm. That night, I (V11) helped CNA (V12) change R1 because R1 was screaming that she wanted to talk to her daughter. I told V12, it is 5am we should just change her. I did not notice V12 was rough with any resident. When I (V11) was in the room with the resident, she was normal. Surveyor asked V11 how was R1's behavior the following night. V11 stated, "Quiet and was not screaming. I saw the bruises on her arm, I did not check her whole body but when I saw her that night of 5/29/2024 I saw the bruises on her arm that was not there when I helped to change her the night before. I saw her body before because she was naked the night I (V11) helped V12. R1 did not say anything to me about what happened that night". I have not seen V12 since that day. I (V11) was not aware of anything that happened to R1 that night. I (V11) went into R1's room because I heard her (R1) screaming and that is why I (V11) went into the room. When I went into R1's room V12 was not in there, she (R1) was sitting by the door, and I called her (V12) into the room, and I said since she was wet let's change her (R1) because sometime that can make them upset and have behaviors. R1 had a roommate, R5 and she can answer questions.

On 6/29/2024 at 10:39am, Surveyor asked V2 regarding incident of 5/31/2024 involving R1. V2 stated, in the morning R1 told morning CNA (V5) that the night CNA (V12) was rough. V5 told V7 and V7 checked R1 and contacted V1 immediately. I interviewed R1 and her story was consistent with the story R1 told me and what R1 told V1. We called the police, and that CNA (V12) was removed from working and then terminated due to findings. R1 stated, the CNA (V12) was rough with her (R1) using the sit to stand and she was sliding back and forth. From my

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understanding, V13 offered to help her, and the CNA (V12) refused the help. R1 stated, V12 was rough with her (R1), she was swinging me back and forth in the chair. R1's body assessment had bruising on right upper arm and within the crease below R1's breast. I (V2) got into the sling, and I think it is possible the sling was upside down and when it is like that it is not as padded. R1 was then showered and brought back to the room. "When I spoke with R1 she seemed frustrated and kind of sad, but very frustrated about the situation". We told her we would investigate and V12 would not be back with her. R1 was pleasant with me, but I did not do any direct care with her. R1 was pretty alert. I do not believe night shift nurse (V11) knew about this situation. Surveyor asked V2 when you spoke to V12 what did she say happened. "V12 denied everything but admitted doing a transfer with only one person". V12 denied knowing about any injury or anything. V12 was immediately suspended. R1 was very alert and R1's statement matched the injury, so we terminated V12, she is not to our standard, you do not treat people like that. Prior to this incident, I did hear a comment that it seemed like V12 did not want to be here, but there was nothing tangible to go on. I had no complaints about the care she gave prior to this moment. No one said there were any concerns during her orientation. V12 was asked how bruises got on the resident (R1), V12 stated, she did not know. Surveyor asked V2 how the sit-to-stand is supposed to be used. V2 stated, "The sit-to-stand we educate 2 people to use the sit to stand, any mechanical lift I want 2 people that is the safest way. I preach all the time that any mechanical lift you have to have 2 people". R1's daughter was notified and came to visit R1 that day. We kept daughter up to date. R1 ended up going to the hospital, I am almost positive due to kidney

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issues and R1 did not return. After this incident, we asked residents if they had any safety concerns. R5 can be confused but did not say anything. It was after 7am when R1 reported, and V12 was done with her shift, and V12 was told not to come in until investigation was completed and we gathered the findings. "Based on findings, V12 was terminated due to improper technique, and she was rough with the patient and the patient has the bruising to show, so we just terminated".

On 6/29/2024 at 11:58am Surveyor asked V13 (CNA) about the incident that occurred 0n 5/29/2024 with R1. V13 stated (in part), I was going in R1's room because I heard R1 screaming. R1 never screams, so I went to see what was wrong. When I walked in R1's arm was inside the sling not outside of the sling. The arm is supposed to be over the sling. V12 had not pulled R1 up yet, I (V13) just fixed it (referring to the sling). V12 was using sit to stand without help. I saw V12 take R1 to the shower. V13 was busy and V13 called me again in the shower room. When I got to the shower room R1 was already in the shower chair. V12 transferred R1 to the shower chair with the easy stand by herself. When R1 was sitting on the shower chair R1 looked like she was going to slide. V12 called me to help push R1 up in the chair. I (V13) said, "No, no we cannot push R1 up because we might hurt her. Then V12 said, ok and I (V13) left. When I went back again, R1 was already in the wheelchair. I believe she used the sit to stand, V12 walked out and R1 was in the wheelchair. R1 did not say anything to me, but she looked like she (R1) was not happy. V12 did not say anything. I worked with V12, and I (V13) do not know if there were any complaints, but I let her do the residents, she was a little rough. The way she changed residents and get up when the resident

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sitting on the chair, she was a little rough, her attitude was okay with me. I tried to tell her what to do and she said OKAY, okay. I (V13) was scared to tell V12, I did not tell anyone because that was my first time working with her.

On 6/29/2024 at 1:21pm surveyor called V12 (CNA) regarding incident that occurred on 5/29/2024 with R1. V12 stated (in part), I do not remember R1's name. but I (V12) remember giving R1 a shower not sure of the day. There was no incident, but they (V1) called me and said she (R1) had a bruise on her arm. I (V12) said, I (V12) do not know anything about a bruise because I (V12) did not see any bruise when I (V12) gave her a shower. V12 further stated, before I (V12) moved her (R1) I was asking questions, because there was no clear instructions on how to move residents. V13 (CNA) told me she (R1) could move. I (V12) asked her (R1) to stand up and get in wheelchair. I (V12) got V13 and told V13 she (R1) could not stand up. I got the sit to stand lift, put strap under her and fixed it while R1 stands holding onto device. V13 helped me (V12) take her (R1) to the bathroom to give her (R1) a shower. R1 had a white plaster on her stomach above her navel and I asked V13 if R1 could get a shower. V13 went to ask nurse (V11) if okay to give shower and V11 said yes. I (V12) gave her (R1) a shower. I (V12) do not remember hurting her and neither did I see any mark on R1. V1 called me and told me R1 had a scar on her arm. I (V12) had assistance by V13. At the facility there is not clear instructions, I (V12) have to always run to V13 to ask. Surveyor asked V12, at any time while you cared for R1 did you pull the R1's arm or handled R1 in a rough manner. V12 stated, I did initially pull her arm when I was told she could stand, but when I saw she could not stand I left

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and got the lift. I (V12) then gave R1 a shower and took R1 and put R1 back in the room I (V12) got R1 dressed and took her (R1) to the room. In the parking lot V13 told me she was a mechanical lift. If residents are not transferred right, the resident can get a bruise. V1 called me and said R1 has a bruise on her arm and said I (V12) was being investigated for abuse and suspended pending investigation. V2 called and said proper care was not given to R1 and I (V12) was going to be separated from the company. I was not told anything else except proper care was not given to the resident. Surveyor asked V12, did you abuse or handle R1 in a rough manner. V12 stated, "No". Surveyor asked how R1 got bruises on her arm, V12 stated, "I do not know R1 did not have any bruises on her".

On 6/29/2024 at 1:57pm V1 stated, I was notified by V7 that R1 had an issue with the CNA, and we determined it was V12. V12 had already left her shift. I spoke with R1 and the daughter. I spoke with the daughter first and she said her mom had significant bruising on her right upper arm. It was definitely new bruising and none of the nurses or daughter had seen this before. Daughter said V12 was rough with her mom (R1) and attempted to lift R1 out of bed alone and R1 was voicing for V12 to stop and pulled oxygen tubing out of R1's nose and gave her a shower, barely putting her under the water according to R1. When I interviewed R1 she told me the same story, what R1 told her daughter is what R1 told me. I (V1) had V9 look her over to assess R1 and she (R1) had bruising under her right breast to her sternum which would explain improper lifting. R1 expressed she was very scared and did not want CNA (V12) to come back into R1's room. R1 seemed very emotionally affected by it. After speaking with them (V17 and R1) I called the

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police. I then called V12 after police left and I asked V12 very specific questions about R1. V12 stated, she (R1) was a resident she was working with. V12 did know who she (R1) was and I (V1) asked how morning went. V12 stated, it went as it should. I (V1) asked specific question did you give R1 a shower and if she (V12) gave proper care. V12 said, yes. I informed her I (V1) heard differently and V12 denied those claims. I then asked V12 how she lifted R1 to get R1out of bed. V12 said she used an easy stand. I asked if she had assistance because R1 was a 2 person assist. From speaking with staff and V17 and R1, I heard she did not have assistance. I asked V12 if R1 expressed she did not want to get out of bed and did not want a shower. V12 said R1 was difficult. I then asked about the oxygen tubing and forcibly pulling it form R1's nose. R1 said nothing. V12 then got upset with the questions and said R1 was difficult and was screaming all night long. I (V1) asked V12 if she was frustrated with R1, and V12 said no and then said R1 is not easy to work with. I ((V1) stated, other staff have said R1 was lovely and pleasant. R1 has BIMS 15/15 and is very aware what is happening around her. I also asked V12 if she was aware of bruising and V12 said no. When I (V12) left R1 she was fine. I told V12 about the allegations and she is suspended pending investigation. V12 said okay and hung up. We notified V12 at the end of the investigation she was terminated. V12 did not seem to care. V12 did not ask why or asked the status of what we found out. Surveyor asked V1 Why V12 was terminated. V1 stated, "I found harm to the resident, and lack of empathy and care for the people she is working with. The bruising was significant". V12 was a new hire might have been her third shift. During V12's orientation, V12 was paired with another CNA and there no concerns that I heard at least. I spoke to

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V11 the night nurse, but the incident was reported to V7. V13 did mention that V12 was hard to work with that morning (5/29/2024) and did not want to receive help. The night nurse V11 stated, she did not see any bruises on R1.

On 6/30/2024 at 4:37pm surveyor called V17 (daughter of R1) regarding incident of 5/29/2024. V17 stated, my mom (R1) passed away. V1 and V2 spoke to me about what happened to my mom when I got to the facility. My Mom (R1) was alert and was able to tell me what happened. I am not sure how forceable she (V12) treated her. I know R1 had a bruise on her arm and underneath her breast that R1 did not have. I am not sure why V12 was forcing R1 to get up from the wheelchair. R1 told me that V12 said to the other CNA that came to check on R1 because she was screaming I (V12) can handle this and closed the door and put R1 in the wheelchair and put R1 underneath the shower. V12 also took R1's oxygen off of R1 and ripped the blanket off the bed. V12 was brutal to my mother (R1). My mom (R1) was such a nice lady. Not sure why V12 did that to my mom (R1). R1 was weak and could not stand but the CNA (V12) made her get in the shower. R1 was trying to tell her she was in pain because she had bedsores but the lady (V12) yanked the blanket from underneath R1 and took the Oxygen off and threw it on the floor. She (V12) put R1 in the wheelchair and forced her to get up yelling at her. When I (V17) got there (facility) R1 had a bruise on her right arm and underneath her right breast area on the same area on the right side. I took a picture of the bruise on her arm, but I (V17) did not get a change to take picture of that bruise underneath R1's breast. The bruise was freshly made, it was red. V12 was trying to make her stand up and she was in pain down in her bottom. I am not sure

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why anyone would do that to R1.

Wound care notes documented date 5/28/24 8AM reads: Resident was up in w/c (wheelchair) facing the open door. Per resident the noc (night) CNA was rude and rough with resident when she took her in the early am for a shower. Noted to have a red mark to her R (right) lateral upper arm as well as under her right breast. Resident was upset and stated she wasn't going to do anything until her dtr (daughter) came. Spoke to resident and informed her will wait for her daughter and assess her skin as well as dress her wound to the sacrum. V9 LPN Per V1 this note was misdated and was documented on 5/29/24 at 8AM when V1 asked wound care nurse to complete a skin assessment on R1 due to allegation of abuse by V12.

5/29/24 visual body map skin for R1 documented by V9 existing sacral sore from admission, red bruising to outer R (right) upper arm, red bruising under R Breast

5/29/24 7-3 in part documents res alert/ verbalizes needs well to staff. Assessed by wound nurse red bruising, R under the breast red bruising to upper R outer arm.

Review of Medical Records, Surveyor did not see any documentation in the medical record regarding how R1 was transferred by V12 on 5/29/2024, nor did facility provide documentation.

Physician Progress note May 29, 2024 10:20 AM document in part: Chief Complaint: Bruises History of Present Illness: female was seen patient was seen on the request of her nurse who reported that patient reported that this morning at 3AM her CNA gave her a shower which she did

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not want to have. She stated that the CNA took off her oxygen and took of the abdominal binder in an abrupt manner and grabbed her right arm which made her to sustain bruises on her right arm and under her right breast. She stated that she was unhappy that she was handled in that manner because that made her very uncomfortable. She stated that this staff member is always nice to her but she did not know what happened today. The facility notified the police and patient's family about this incident. I notified Dr. who is the physician at this facility. She denied any pain. Physical exam General: awake, alert, elderly, not in respiratory distress, up in bed. Skin - new rt arm bruise and an old bruise with small excoriation under rt breast. Psychiatric - oriented x3, Diagnosis, Assessment and Plan Bruise Right arm and under right breast bruises, keep areas dry and open to air. Hypoxia give oxygen at 2 L via Nasal cannula.

Nursing note 5/29/24 3-11 in part document res on bed alert & oriented with O2 (oxygen) 2L (liters)/min (minute) Spo2 (Oxygen Saturation) 97-98% bruise on the Rt (right) upper no s/s (signs/symptoms) of infection and no complained of pain.

Nursing note 5/30/24 11-7 in part documents resident in bed, alert oriented x 2-3 w/ (with) periods of confusion, O2 2L via N/C (nasal cannula) - 93%. Still w/ bruises to right outer arm & right under breast. No swelling noted, skin intact.

Facility Abuse Prevention Policy (last revised 06/2020) documents in part: Policy Statement Our residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.

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S9999	Continued From page 18 Job Title: Nursing Asst Cert-LTC dated 11/17/2022 documents in part: Job Summary: Assists with basic patient care activities. Responsibilities: Assists patients with tending to personal care, activities of daily living and transfers/transport. Complexity of Work: Within scope of job, ability to work with minimal supervision. Must be able to work in a stressful environment. Facility Procedure: Lifting Machine, using a Portable last approved 04/2024 documents in part: Purpose The purpose of this procedure is to help lift residents using a manual lifting device. Preparation A. Review the resident's care plan to assess for any special needs of the resident. General Guidelines Two (2) nursing associates are required to perform this procedure. Procedure For Sit-to-stand: B. Position sit-to-stand lift sling under resident's axilla and secure safety belt around waist. I. crank the resident up with the lift. Your helper *guides the resident by holding the sling. Documentation The following information should be recorded in the resident's medical record: B. Amount of assistance that was given and the number of people who assisted. Facility's "Assessment Tool" (FY24) documents in part: Services and care we offer based on our residents' needs: Provide person centered/directed care: identify hazards and risks for residents. Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies, Staff training/education and competencies are necessary to provide the level and types of support and care needed for our resident population, Topics Activities of daily living - using mechanic lifts.	S9999		

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