STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000889	A. BUILDING: _____ B. WING _____	C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Initial Comments Complaint Investigation: 2498409/IL00179394	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300. 1210b) 300.1210d)6) 300.1220b)3) 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 plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999		

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S9999	Continued From page 1	S9999		

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 300.1220 Supervision of Nursing Services

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

These Requirements were not met as evidenced by:

Based on interviews and records reviewed, the facility failed to ensure fall prevention interventions were utilized to include nonskid footwear and other appropriate interventions for 1

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S9999	Continued From page 2	S9999		

resident (R3) and provide assistance to one resident (R2) during transfer from wheelchair to bed. R3 has a cognitive communication disorder, poor safety awareness, and impaired cognition. R2 has a history of alcohol abuse, gait disorder, and neuropathy. These failures affected two of three (R2, R3) residents reviewed for falls. These failures resulted in harm, with R2 sustaining a laceration requiring two sutures to the left eyebrow region, and R3 was admitted to the hospital for Subdural Hematoma and received 7 staples to the left occipital region.

The findings include:

1. IDPH facility reported an incident for R3 states on 9/2/24. The nurse on duty observed the resident standing by the bed and attempting to walk. Nurse attempted to get to the resident to prevent him from falling. Resident fell on the floor between the bed and night stand. The nurse noted a laceration of approximately half an inch on the left posterior head and minimal bleeding on the lower mouth. The resident was taken to the emergency room, and the facility notified that the resident was admitted with a diagnosis of Subdural Hematoma.
On 10/29/24 at 1:37 PM, V6, Certified Nursing Assistant (CNA), said around 11:00 AM, I saw Physical Therapy bringing R3 to his room, and therapy put R3 back to bed; the nurse and I checked him. V6 said I did not see R3 fall but saw him on the floor. R3 was between the bed and the nightstand. V6 said R3 kept asking us to get him up, but we left him in the position on the floor, and he kept trying to get up. V6 said it was out of his behavior for him to get up unassisted. V6 said R3 did not use a walker with her. V6 said R3 had a regular wheelchair. V6 said I don't remember what kind of shoes R3 had. V6 said R3 fell

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S9999	Continued From page 3	S9999		

between 11:00 AM and 12:00 PM. V6 said I don't remember getting R3 up that day. V6 said the night shift usually takes R3 to dialysis in the morning before she gets on the unit. V6 said I didn't put shoes or socks on R3. V6 said R3 did make some urine but had not used the urinal or been incontinent at the time of the fall. V6 said that generally, R3 was alert and oriented, but that day, R3 was out of his behavior.

On 10/23/24 at 2:20 PM, V3, Licensed Practical Nurse, said 9/2/24 R3 went to dialysis that morning; he was already off the unit when V3 came in; dialysis starts at 6:00 AM. V3 said around 10:00 or 10:30 AM, R3 was in bed with the CNA, making him comfortable. V3 said I checked R3 and he said he was just tired. V3 said at 11:00 AM, when I passed R3's room, he was in bed sleeping. Then he called me and wanted to be changed about 11:00-11:30 AM, and the CNA went to change him. V3 said while V6 was changing R3, I was at the desk, then V6 went to take the next patient to dialysis, and I remained at the desk. V3 said at 12:00 PM, I went to do blood sugar checks. V3 said I saw R3 was standing out of the bed, already losing his balance. V3 said, "I was too late. He fell." V3 said R3 was trying to reach for the chair in the room, but he still fell. V3 said R3 had blood in his left hand and bottom lip. I called 911 and left him on the floor with V6. V3 said there was blood on the pillowcase V6 had placed under R3's head. V3 said R3 was bleeding from the back of his head. V3 said I had not seen R3 get up on his own before. V3 said sometimes R3 will shoot us away if we help him. V3 said R3 had fallen Friday before 9/2/24. V3 said when I came in for my shift, the night nurse said they found him on the foot of the bed on 8/30/24. V3 said on 9/2/24, R3 had a gown on, and he was barefoot. V3 said R3

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S9999	Continued From page 4	S9999		

came to us because he had fallen in the past. V3 said R3 may have had a bowel movement and still makes urine. V3 said R3 was in a regular bed, and it did not go to the floor. V3 said R3 had no walker or cane, just a wheelchair. V3 said we did not have floor mats in place for R3. V3 said it was not like R3 to get up on his own.

On 10/23/24 at 12:48 PM V2, Fall Coordinator, said R3's behavior he was non complaint with cares, he was new to dialysis, had depression, and he had multiple falls at home. V2 said on 8/30/24, R3 stood up to try to go to the bathroom; he is weak from hospitalization and dialysis. V2 said R3 did not call for help, he fell and intervention was to continue therapy. V2 said on 9/2 24, R3 was seen at 11:30 AM in bed resting; the nurse did not wake him. V2 said R3 had already had dialysis on 9/2/24. V2 said the nurse went in to check R3's blood sugar at 12:10PM. V2 said R3 had taken a step from the bed and fell and hit his head. V2 said V3 witnessed the fall. V2 said R3 fell between the bed and nightstand and he hit his head on the nightstand. V2 said R3 said I was going to go sit in my wheelchair and he thought he could do it. V2 said R3 was noted bleeding and R3 remained on the floor until ambulance came for him. V2 said the hospital notified us that R3 had a Subdural Hematoma and was in the intensive care unit for care. V2 said R3 died in the hospital of cardiac arrest and aspiration pneumonia.

On 10/23/24 at 2:36 PM, V4, Director of Rehab, said R3 was on caseload from 8/14/94 through 9/2/24. V4 said R3 required moderate assistance for transfers. V4 said R3 was ambulating with minimal therapist assistance with a rolling walker. V4 said the CNA would need to use a gait belt, give cues, and some assist to get him to stand.

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S9999	Continued From page 5	S9999		

V4 said barriers for therapy for R3 were poor motivation, behavior, and he was refusing to participate in therapy. V4 said R3's balance fluctuated and is not the best, especially after dialysis, and poor after treatment related to fatigue. V4 said for residents on case load we will tell the nurse the level of support the resident needs and if they are a high fall risk we encourage them to have their walker. V4 said for R3 staff should not be using the walker with him.

On 10/23/24 at 3:00 PM, V5 Restorative Nurse said R3's orientation fluctuated; he was incontinent, but he was not producing urine.

R3's diagnosis include but are not limited to End Stage Renal Disease, Dependency on Renal Dialysis, Adjustment disorder with Mixed Anxiety and Depressed Mood, Abnormalities of Gait and Mobility, Lack of Coordination, Abnormal Posture, Cognitive Communication Deficit, Anemia, Type 2 Diabetes Mellitus, Hypertension, Congestive Heart Failure, and Presence of Cardiac Pacemaker. R3 was admitted to the facility on 8/14/24 and discharged to an acute care hospital on 9/2/24.

Incident report dated 8/30/24 for R3 states around 4:45AM patient observed lying on his back on the floor next to bed. Patient stated he was trying to go to the washroom when he lost his balance. Blood pressure 91 / 50 pulse 105. Mental status oriented to person and place, lack of safety awareness. Post-fall investigation states activity at the time of incident: attempting to stand or transfer to get out of bed. Mental status at the time of the incident: poor safety awareness. The factors that contributed to the incident: attempting to stand transfer without assistance. Resident at risk for falls: fall risk score 16, resident has a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 6	S9999		

history of falls, multiple files prior to admission. Interventions used to bed in the lowest position, call light within reach, and education to use call light for assistance. Root cause analysis states that the resident recently started dialysis and was hospitalized due to multiple falls and episodes of dizziness. The resident is currently here for therapy for strengthening. Per resident he got up from his bed to go to the washroom and lost his balance. Per staff, the call light was next to the resident but was not activated. Resident fell because resident unsafely transferred himself without assist despite unsteady gait and balance. Resident has a BIMS (cognition assessment) score of 10, which indicates moderate cognitive impairment, so he forgets to use the call light at times. Interventions: continue with skilled therapy for strengthening.
The incident report dated 9/2/24 states that the nurse went to the patient's room. Observed R3 standing by the bed and attempting to walk but began to lose balance. The nurse attempted to get to the resident to prevent him from falling, but the resident fell between the bed and the nightstand. The resident stated I was trying to go sit in the chair. I thought I could do it myself. R3 noted with a laceration approximately half inch on the left posterior head and mild bleeding of the lower mouth. Blood pressure 108/62 pulse 74. R3 remained on the floor until paramedics arrived. Injury observed: laceration back of the head. Mental status: alert with periods of forgetfulness. Post-fall investigation states resident injury: Subdural Hematoma. Activity at the time of incident: attempting to stand or transfer to get out of bed. Mental status: poor safety awareness. Environmental factors: attempting to stand transfer without assistance. Date of last fall: 8/30/24. Interventions: bed in the lowest position, call light within reach, skilled therapy. R3 was

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S9999	Continued From page 7	S9999		

sent to the hospital post-fall with injury via 911. R3 was admitted with a diagnosis of Subdural Hematoma. Root cause analysis: R3 has poor decision-making skills. He overestimated himself to perform tasks independently and unsafely transferred himself without assistance despite unsteady gait and balance, causing him to lose balance and fall. R3 has poor safety awareness and impulsive behavior. On 9/2/24 at 6:00 AM R3 went for dialysis. Increased weakness, fatigue, and dizziness are mild symptoms after dialysis treatment, which may have contributed further to his fall.

R3's Cognitive assessment dated 8/16/24 notes a score of 10. R3's behavior assessment dated 8/16/24 notes he has verbal behavioral symptoms directed towards others (threatening, screaming, cursing). Behaviors put the resident at significant risk for physical illness or injury. Significantly interfere with care. No rejection of care was exhibited. Functional abilities notes toileting and personal hygiene R3 requires substantial/maximal assistance with helper doing more than half the effort. Standing, transfer from chair to bed, bed to chair, and toilet R3 was dependent on staff. R3's bowel and bladder assessment noted R3 was always incontinent of bowel and bladder. R3's appliances assessment notes he has an indwelling catheter, external catheter, ostomy, and intermittent catheterization.

R3's Admission assessment, dated 8/14/24, notes a fall risk evaluation of 4, low risk. The assessment notes that R3 is continent of bowel and bladder. The resident has a short-or long-term memory problem. The resident is able to walk with assistance or an assistive device. Gait is not applicable. The history of falls states no, and it is unknown if the resident has fallen in

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S9999	Continued From page 8	S9999		

the past three months.

R3's care plan dated 8/16/24 states at high risk for falls related to decline in functional status, impaired balance during transitions, impulsivity or poor safety awareness, multiple falls prior to admission and muscle weakness from recent hospitalizations. Goal states R3 will be free of falls through next review date. Interventions dated 8/16 include call light and reach and encourage to use for assistance. Staff to provide a safe environment. Therapy to evaluate and treat as ordered to increase strength and mobility and prevent further falls. Keep needed items within reach, such as urinal. Intervention dated 8/30/24 states continue with skilled therapy.

The speech therapy evaluation and plan of treatment dated 8/15/24 state that memory and safety awareness have been declining recently. The patient is memory impaired. The reason for therapy is that the patient presents with moderate problem-solving and safety awareness skills. Barriers likely to impact discharge to the next level of exasperation of cognitive impairment include lack of insight into the condition and risk factors.

The physical therapy evaluation and plan of treatment dated 8/15/24 states, "Has the patient fallen in the past year? Yes, six times per patient. The patient feels unsteady when standing and worries about falling."

R3's hospital record dated 9/2/24 notes he received 7 staples to the left occipital side. R3 was admitted to the intensive care unit (ICU) for the management of Subdural hematoma. R3 did not return to the facility.

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S9999	Continued From page 9	S9999		

2. IDPH facility reported incident for R2 states on 10/13/24 nurse heard resident calling for help. Nurse observed resident sitting on the floor in his room. Resident stated I was trying to transfer myself but missed the bed, I hit my face on the side of the wheelchair and landed on the floor. R2 sent to hospital for evaluation of laceration on the left eyebrow measuring 1.0 X 0.3 centimeter with bleeding. R2 returned after few hours with diagnosis of laceration of forehead. Observed with sutures on left eyebrow.

On 10/23/24 at 12:03 PM V8, RN, said on 10/13/24 I was passing medications, I heard someone calling for help. V8 said when I saw R2 he was kneeling at the side of the bed. V8 said I saw blood on the left eyebrow. V8 said R2 said I want to transfer
myself. V8 said R2 thinks he can do things by himself, but he refuses to use the call lights. V8 said R2's roommate said R2 transferred himself. V8 said R2 hit his eyebrow on the bedside table. V8 said R2's call light is always in his reach and we have to remind him to use it. V8 said supervision is what we do for R2. V8 said R2 said he wanted to get into the bed. V8 said R2's mental status is causing him to fall. V8 said sometimes he understands direction. V8 said R2's current roommate wants the door closed, so it gets closed. V8 said R2 will transfer himself on and off the toilet.

On 10/23/24 at 12:37 AM V9, CNA, said R2 refuses when you help him. V9 said R2 will stand up, closes the door and he just keeps doing what he was doing. V9 said R2 transfers himself, he wants to be independent. V9 said R2 gets up to walk into the bathroom. V9 said I will try to open the door for R2, and he sometimes wants the door open. V9 said I don't know if R2 would use

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S9999	Continued From page 10	S9999		

the urinal or commode. V9 said if R2 falls he will try to stand up by himself.

On 10/23/24 at 2:02PM R2 interviewed in tv room, no staff observing the area, only as they walk past. R2 said I don't know why I keep falling. R2 said my knee, (points at left knee) hurts or gives out. R2 Speaks in low soft tone.

On 10/23/24 at 12:28 PM V1, LPN said R2 was trying to go to the bathroom by himself on 10/6/24. V1 said I had just talked to R2 in the hall. V1 said R2 did not ask for assistance, he never told me he had to use the washroom. V1 said I was doing
medication pass when he went past me. V1 said then I heard something and I saw R2 on the floor in the room. V1 said I don't recall what he said.

On 10/23/24 at 12:48 PM V2 Fall Coordinator, said R2 is very alert he knows when to call. V2 said R2 gets mad if you try to help him. V2 said I called the daughter to ask what we can do. V2 said I speak with R2 often to call for assistance, but he won't call. V2 said R2's leg is unstable and we have him working with physical therapy to work with safety. V2 said the plan for R2 is he needs frequent checking on even if he refuses. V2 said R2 is alert, he can press the call light, and we continue to remind him. V2 said R2's room is close to the nurses' station, to keep checking on him. V2 said R2 has fallen in the common areas and in his room.

On 10/29/24 at 1:05 PM, V2 said that on the fall risk assessment, a score of 8 or more is high risk, 7 or below is low risk, and everyone is at risk. V2 said 10 is a high risk. V2 said a history of alcohol abuse places someone at risk for cognition or balance problems. V2 said I can use the BIMS to

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S9999	Continued From page 11	S9999		

determine the resident's cognition. V2 said a new BIMS (cognition assessment) is not usually done with a fall, only for changes in behavior.

On 10/23/24 at 2:36PM V4, Director of Rehab, said R2 has been seen with therapy. V4 said R2 was last seen 10/15/24 thru 10/21/24 and prior to that 5/6/24 to 5/17/24. V4 said for 10/15/24 R2 had another fall and we recommend to see him again to educate on safety and body mechanics. V4 said R2 participates with interventions but he demonstrates poor safety awareness and poor insight to deficits. V4 said R2 required assist with ambulation for safety. V4 said R2's deficits include he is impulsive. V4 said at the time of discharge in May 2024 R2 has the ability to transfer with moderate assist and ambulate with moderate assist. V4 said R2 assistive devices include a wheelchair and rolling walker. V4 said R2 has poor carryover and is very challenging. V4 said the responsibility of activating the call light for help should not be on him. V4 said we anticipate him resisting and declining assistance. V4 said we have done extensive education and reminders for R2 to use the call light. V4 said when ambulating R2 leans back and we prefer staff just wheel him up to the toilet.

On 10/23/24 at 3:00 PM V5, Restorative Nurse, said R2 can propel in the wheelchair by himself. V5 said R2 can stand by himself, but he needs supervision because of poor bilateral lower extremity strength. V5 said R2 is able to stand but not safe alone. V5 said R2 does not use a walker or a cane to ambulate, he can't walk. V5 said I can't remember if R2 is using a walker. V5 said the urinal could be helpful for R2. V5 said R2 was not offered a urinal. On 10/29/24 at 2:21 PM, V5 said R2 restorative programs include active range of motion, dressing, and grooming.

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	IL6000889	A. BUILDING: _____ B. WING _____	C 10/30/2024

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S9999	Continued From page 12	S9999		

V5 said R2 was not walking with nursing before last week. V5 said the the MDS is incorrect for 10/4/24, R2 was not walking with a walker at that time. V5 said his endurance was poor when R2 was walked last week; he has a crisscross gait pattern, and he needs cueing, hands-on assistance, and a wheelchair to follow. V5 said R2's posture is poor he looks down when walking.

On 10/30/24 at 1:51 PM, V10, the Physician said R2's neuropathy could affect his ability to know where he is putting his feet to walk. R2's history of alcohol abuse may cause him to have some cognitive issues. Proprioception (perceiving location of movement) and cognition can be affected. R2 can be more impulsive due to the alcohol affects on his frontal lobes and cerebral effects. V10 said R2 can be alert and oriented and have less ability to compensate for balance. V10 said we can do a neuropsyche consult to see if there could be subtle issues affecting impulsivity and following instructions.

R2 diagnosis include, but not limited to history of Maxillary Fracture (1/17/23), Zygomatic Fracture (6/13/24), Fall (9/18/23), Laceration (9/18/23), Alcohol Abuse, Hypertension, and Vitamin D Deficiency. R2 admitted to the facility on 1/17/23.

Progress notes dated 3/15/24 written by V10, Physician, documents R2 with history of gait disorder likely from alcohol abuse and neuropathy seen earlier today due to fall few days ago.

R2's fall risk evaluation dated 8/24/24 indicates score of 10, high risk. Mobility the residents gate described as unsteady.

On 8/24/24, R2's incident report states that the nurse was informed that the resident slid out of

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S9999	Continued From page 13	S9999		

his chair and was on his bottom in the dining room. Mental status forgetful.

On 10/6/24, R2's incident report states that at approximately 11:45 AM, the nurse heard a little commotion. The nurse went to the resident's room. The resident was sitting on their buttocks and fell unwitnessed. The resident stated I was trying to go to the bathroom. Mental status lack of safety awareness and forgetful. Post fall investigation states activity at the time of incident: attempting to stand or transfer. Mental status: poor safety awareness. Environmental factors: attempting to stand transfer without assistance. Fall risk: resident at risk for falls evaluation score 10. Resident has history of falls last fall 8/24/24. Interventions bed in lowest position, call light within reach, education to use of call light. Root cause analysis: states resident with history of hypertension alcoholism was brought by family for continued weakness and falls at home. Patient has become increasingly difficult to care for self. Was a functional alcoholic. A cognition score of 15 indicates intact cognition. Resident fell on 10/6/24 because resident unsafely transferred himself to the bathroom without any assisted device and staff assistance call light was not utilized. Resident is non-compliant and overestimated self to perform task independently causing him to fall. Intervention resident will be provided with visual prompts to ask for help to help him communicate his needs.

On 10/13/24 R2's incident report states nurse heard resident calling for help. Nurse observed resident sitting on the floor. Resident said that he transferred himself from wheelchair but unable to reach the bed and, hit his left eyebrow at the edge of the bedside table and sustained a small laceration with bleeding. Residents said I

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S9999	Continued From page 14	S9999		

transferred from my wheelchair but missed the bed. Laceration on the left eyebrow measuring 1.0 by 0.3 centimeters with bleeding. Set to emergency room for evaluation and treatment via 911 Mental status alert with periods of forgetfulness lack of safety awareness. Post fall investigation states resident was last seen on his wheelchair he propelled himself to his room. Resident verbalized he is OK and does not need any further assistance. Nurse reminded resident to press call light when needed. Activity at the time of incident: attempting to stand or transfer. Mental status: poor safety awareness. Environmental factors attempting to stand transfer without assistance. Resident at risk for falls evaluation score 13. Fall interventions in place bed in lowest position, call light within reach, visual prompts provided. Resident was sent to hospital post fall and returned to the facility with stitches to left eyebrow. Root cause analysis: according to the resident, he was unable to reach the bed and hit his left eyebrow at the edge of the bedside table and sustained a laceration with bleeding. Resident was last seen sitting on his wheelchair. Resident is aware about the call light use but prefers to do task independently. He is assessed at high risk for falls and noted to be overestimating his capability at this time to perform task independently resulting in fall.

R2's care plan dated 5/25/23 states he is at high risk for falls related to impaired balance during transitions, impulsivity or poor safety awareness, history of multiple falls and recent falls. Goal R2 will be free of falls through next review date. Interventions include I have periods of forgetfulness-staff to provide me a safe environment. Re-educate to use call light and remind to ask for assistance.

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S9999	Continued From page 15	S9999		

R2's care plan, dated 9/18/23, states that the resident is noncompliant with the call light and transferring. I may not necessarily understand my physical limitations. I am noted to be non-compliant, omitting to use my call light or asking for assistance prior to transferring. I display poor decision-making and poor judgment. Interventions include anticipating resident needs.

R2's cognitive assessment score on 10/4/24 is 15. No behaviors were exhibited on the behavior assessment dated 10/4/24. The functional abilities assessment on 10/4/24 notes that R2 requires substantial to maximal assistance with hygiene and is dependent on staff for toileting. Our two mobility devices include a Walker and a wheelchair. The assessment on 10424 indicates that R2 ambulates with assistance.

R2's quarterly restorative assessment dated 93024 indicates he requires assistance with ambulation and transfer and has a fear of falling.

R2's resident education, dated 6/14/24, educated the resident regarding orientation to the call light. This is the last resident education documentation provided for R2.

A list of R2's incidents include fall on 3/15/24; 5/2/24; 6/13/24; 8/24/24; 10/6/24; and 10/13/24.

R2's physical therapy discharge summary dated 5/17/24 notes restorative program range of motion program active range of motion on both lower extremities as tolerated.

R2's physical therapy discharge summary dated 10/23/24 states a restorative program for ambulation and passive range of motion.

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S9999	Continued From page 16 Ambulation 150 feet using a rolling Walker with minimal assistance and close wheelchair follow for safety. R2's hospital record dated 10/13/24: Laceration Repair on the left eyebrow with 2 sutures. The facility Fall Occurrence policy dated 7/26/24 states it is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place, and interventions are reevaluated and revised as necessary. Those identified as high risk for falls will be provided fall interventions. The interventions will be reevaluated and revised as necessary. (A)	S9999		