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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 330.710 a) 330.710 c)3)F) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. c) The written policies shall include, but are not limited to, the following provisions: 3) 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: 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.	S9999		

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This REQUIREMENT was not met as evidenced by:

Based on observation, interview, and record review the facility failed to properly transfer two residents (R1, R3) with a history of falling and failed to ensure a resident (R1) had proper footwear to prevent a fall. These failures affect 2 of 3 residents reviewed for falls on the sample list of 7.

Findings include:

1. On 10/8/24 at 9:00 AM, R1 was self-ambulating from the hallway toward the activity area. R1 was taking small, slow steps with her walker. R1 had to go to the bathroom. V5 (CNA - Certified Nursing Assistant) assisted R1 to a wheelchair and took R1 to the bathroom. After toileting V5 (CNA) pushed R1 in the wheelchair to her walker, parked in the hallway. V5 locked the brakes on the wheelchair, placed R1's walker in front of her and instructed R1 to stand up. V5 had a gait belt around her waist. V5 did not place the gait belt on R1 to assist her to a standing position. V5 positioned herself behind R1's wheelchair and pulled up on R1's pants to assist R1 to a standing position. V5 instructed R1 to continue walking to the activity. R1 took very small steps to slowly walk to the activity room, without a gait belt on. R1 told V5 that her arm hurt. V5 told R1 that she went to the hospital and her arm wasn't broken, but it would probably be sore for a little while. At 11:40 AM, R1 was sleeping on a couch in the activity room. V5 woke R1 up and told her it was time for lunch. R1 opened her eyes and looked around the room. V5 set R1's walker in front of her and instructed her to stand up. R1 sat and stared blankly. V5

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repeated her instructions to R1. R1 rocked forward and attempted to stand, while V5 pulled up on the back of her jeans. R1's bottom came off the couch, but she was unable to stand and fell back into the couch. V5 stated, "I can't do it all [R1], I need you to help me." They repeated the rocking motion, V5 pulled on the back of R1's pants and R1 stood. V5 did not place a gait belt on R1, it was still around V5's waist. R1 started to take small unsteady steps forward. V7 (LPN - Licensed Practical Nurse) told V5 to follow R1 with her wheelchair because she was unsteady. V5 stopped R1 and said, "you seem weaker today" and placed the gait belt around her and sat her down in the wheelchair.

R1's October 2024 Physician's Order Sheet (POS) showed R1 had diagnoses to include, but not limited to: osteoporosis, seasonal allergies, overactive bladder, Alzheimer's, and hypertension.

R1's Incident Report dated 9/29/24 showed CNA was walking R1 to the bathroom with her walker without socks and shoes. R1 fell with the CNA present. This form showed Fall Follow-up on 9/30/24. The note showed R1 was complaining of pain in her right arm when she was transferring. This form showed R1 was complaining of right shoulder pain and yelling in pain. R1 had difficulty with standing and Tylenol was administered for pain. R1 had a previous Incident Report dated 4/29/24 for an unwitnessed fall in her room.

On 10/8/24 at 2:13 PM, V2 (Interim DON - Director of Nursing) said if a staff member is walking with a resident or needs to put their hands on a resident to assist, then the resident should have a gait belt on. V2 said a gait belt allows the CNA to have a firm grip on the resident

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to assist them with keeping their balance. V2 said if a resident starts to fall, then the staff can control the fall to potentially prevent and/or minimize the injuries. V2 said the CNAs should not pull residents up by their pants, that's what the gait belt is for. V2 stated, "They should know that." V2 said before taking a resident to the bathroom, the CNA should ensure proper foot wear (gripper socks or shoes) are on the resident. V2 said the facility doesn't have carpet floors and they floors are like ice if the resident doesn't have footwear with grip on them. V2 said she usually works at night and R1 can ambulate, but usually requires the assistance of two staff members. V2 said R1 had been complaining of right shoulder pain since she fell. V2 said she wasn't working when R1 fell, but she reviews the incidents. V2 said R1 was sent to the emergency room after the fall, but there were no fractures found. V2 said R1 returned to the facility, but had been complaining of right arm pain since the fall.

On 10/8/24 at 3:00 PM, V8 (CNA) said she was assisting R1 the morning of 9/29/24 (when R1 fell). V8 said R1 was getting out of bed and screaming. V8 said R1 was holding her walker and started to wobble back and forth. V8 said she tried to stop R1 from falling, but she couldn't. V8 said the nurse called the ambulance and R1 went to the hospital. V8 said R1 wasn't wearing shoes or socks when she fell. V8 said R1 screamed before she fell, then was quiet for a while, but screamed when she was transferred to the wheelchair and then to the stretcher.

On 10/8/24 at 2:50 PM, V7 (LPN) said she was working the day R1 fell. V7 said she had her medication cart, outside the pink dining room (a few doors down from R1's room). V7 said she heard yelling in R1's room. V7 said R1 was sitting

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on the floor, on her butt and had no socks or shoes on. V7 stated, "I asked [the CNA] why she didn't have shoes or socks on because she has an unsteady gait. I had to re-educate the CNA about that." V7 said she didn't see a gait belt on R1. V7 said R1 was complaining of right shoulder pain.

On 10/9/24 at 9:47 AM, V1 (Administrator) said she was unable to locate the facility's gait belt policy. V1 said she knew the facility had one and it was driving her crazy that she couldn't locate it. V1 said she provided checklists to show that the CNAs are expected to use gait belts during hands-on transfers and ambulation with the residents.

The facility's CNA Training Check Off List (updated 8/20/20) showed, "...8. Trainees aware of all fall risks and any resident that may have any kind of alarm/floor mat... 17. Trainee is able to properly use his/her gait belt. 18. Trainee is able to properly transfer from wheelchair to chair and from chair to wheelchair... 22. Trainee is able to properly ambulate a resident with a walker and a gait belt.."

The facility's Safety Responsibility and Rules Policy showed, "...6. Always have assistance/appropriate safety equipment when lifting/transferring a resident. Do not begin a task if you have any doubts as to how it is to be done. Ask your supervisor to determine the safe way to do the task. Asking for help when you are unsure reduces the chance of injury..."

The facility's undated Safe Patient Handling Program showed, "Scope: Whenever a resident requires assistance in moving or transfer at [the facility] this policy will be followed. Purpose: This

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policy has been developed to protect the health and comfort of residents and employees when residents require assistance in transferring or moving, through the consistent use of mechanical aids/devices and/or safe manual lifting and moving techniques and to meet regulatory requirements... Definitions: ...c. "Safe lifting equipment" means mechanical equipment designed to lift, move, reposition, and transfer residents, including, but not limited to: mechanical full-body lifts, mechanical sit to stand lifts, slide sheets and boards, slings, wheelchairs, commode chairs, shower benches, toileting chairs, gait belts/transfer belts and repositioning/turning sheets...

2. On 10/8/24 at 11:43 AM, R3 was sitting in a recliner in the activity room. V5 (CNA) informed R3 that it was time for lunch. The surveyor walked to the dining room to observe the noon meal, but the trays had not arrived. Upon returning down the hallway, the surveyor passed V5 in the hallway. V5 was walking backwards, pulling R3 in a wheelchair. The wheelchair had no foot rests and R3's black sneakers were dragging on the floor. R3's sneakers occasionally squeaked from dragging on the floor. V5 took R3's wheelchair backwards from the activity room, down the hall, into the pink dining room. R3's feet dragged on the floor the entire time.

R3's October 2024 POS showed he had diagnoses to include, but not limited to: diabetes, hypertension, dementia, and pain.

R3's Incident Reports dated 3/11/24, 5/14/24, 8/7/24, and 9/19/24 showed he had falls with no injuries.

R3's Care Plan initiated 8/23 showed he had an

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S9999	Continued From page 6 alteration in mobility and used a wheelchair as needed. On 10/8/24 at 2:13 PM, V2 (Interim DON - Director of Nursing) said it's not safe to transfer R3 backwards in a wheelchair, with his legs dragging. V2 said he could have flipped right out of the wheelchair. V2 said R3 is still pretty strong and ambulates well. V2 stated, "He likes to walk. I don't understand why they would do that, unless he was in a hurry for some reason." V2 said they still shouldn't have pulled the wheelchair backwards like that. It's not safe. (B) Statement of Licensure Violations 2 of 2 330.1160c) 330.1160d) Section 330.1160 Vaccinations c) A facility shall administer or arrange for administration of a pneumococcal vaccination to each resident in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, who has not received this immunization prior to or upon admission to the facility unless the resident refuses the offer for vaccination or the vaccination is medically contraindicated. (Section 2-213(b) of the Act). d) A facility shall document in each resident's medical record that a vaccination against pneumococcal pneumonia was offered and administered, arranged, refused, or medically contraindicated. (Section 2-213(b) of the Act).	S9999		

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S9999	Continued From page 7 This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to ensure pneumococcal vaccination status were documented, failed to ensure pneumococcal vaccinations were administered, and failed to ensure pneumococcal vaccinations were tracked in the medical record for 2 of 5 residents (R1, R7) reviewed for vaccinations on the sample list of 7. Findings include: On 10/8/24 at 9:55 AM, the surveyor requested Pneumococcal vaccination records for 5 residents from V1. At 2:13 PM, V2 (Interim DON - Director of Nursing) provided various documents for the 5 residents. The surveyor asked V2 if she oversees the Immunizations. V2 said she is the "very interim" DON. V2 said she works full-time nights. V2 said she reviews the accidents and incidents and ensures the Abnormal Involuntary Movement Scale (AIMS) assessments are completed, but has not had time to do anything with immunizations. V2 said she had been covering as "interim DON" since June 2024. V2 said she thought the residents may have received the pneumonia vaccines when the pharmacy came in to give the flu shots. V2 said V3 (Social Services) was working with the pharmacy. V2 said there should be records of when the resident last received the vaccines and when they are do next, but she is not tracking this information. V2 said she doesn't think anyone is tracking the pneumonia vaccines right now. V2 said when the residents are admitted the nurse is supposed to ask the immunization history and document it. V2 said the purpose of the vaccines is to prevent	S9999		

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illness and reduce the risk of more severe symptoms if a resident does get ill. V2 stated, "99% of our residents are willing to get the vaccines."

On 10/9/24 at 8:42 AM, V3 (Social Services) said she is helping obtain the consents for the upcoming flu clinic. V3 said last year the previous DON handled most of it, but this year she is trying to help. V3 said she doesn't know much about the pneumococcal vaccines and she's not doing anything with them. V3 stated, "Last year [the previous DON] talked about having pneumonia vaccines, but she never followed through with it." V3 said she was not a nurse and was unsure how often the pneumococcal vaccines needed to be given. V3 said there isn't a consistent process with how the facility handles the vaccines and is aware that there are several different forms being utilized. V3 said she's not sure who is overseeing the vaccines now, "maybe [V2]?"

On 10/9/24 at 9:47 AM, V1 (Administrator) said the pneumococcal vaccines would be tracked by the resident's physician and if it was ordered, then the nurses' could administer the vaccine. V1 said the facility didn't have a process in place for the pneumococcal vaccine and they had never done a clinic for the pneumococcal vaccines. V1 said the nurse should be asking the residents about their immunization history during the admission process. The surveyor asked what form that would be documented on. V1 replied, "The Nursing Admission Assessment." The surveyor showed V1, R3's Nursing Admission Assessment (the vaccine history was not addressed on this form) and asked where it was documented. V1 said she wasn't sure, but she knew she'd seen it before. At 10:12 AM, V1 returned to the conference room with R3's

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Immunization Standing Orders Form and stated, "This is what the nurse should be completing." The surveyor asked where it is documented that R3 received the Pneumococcal vaccine or when she received it last. V1 replied, "It doesn't." R7's document was lacking the Pneumococcal information as well. V1 replied, "I see."

R3's Physician Medication Standing Orders dated 8/25/2020 showed, "...6. Pneumococcal vaccine every 10 years or as otherwise ordered (last received: _____)..." The date it was last received was blank.

R3's Pneumonia and Influenza Vaccine Policy signed 8/31/20 showed, "[The facility] advises all prospective and current residents on the recommendation for all elderly persons to receive an annual Influenza vaccine and Pneumonia vaccine at an interval recommended by your family physician. We will inquire as to your immunization status in both of the above listed areas at the time of your admission. If you are in need of either vaccination, we will obtain permission from you or your representative and your doctor for you to receive the vaccination as appropriate. It is your right to refuse either vaccination, however it is seriously recommended that you receive them..." R3's Pneumo received date and where lines were blank.

R7's Facesheet showed he was admitted 2/11/23.

R7's Pneumonia and Influenza Vaccine Policy signed 1/30/23 showed the Pneumonia shot received and where lines were blank.

The facility's undated Infection Control Techniques/Policies and Procedures showed, "...Admissions - Communicable

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S9999	Continued From page 10 Disease/Infection: Purpose: It is the policy of this facility that admission is dependent upon the facility's ability to provide appropriate medical and nursing care. The facility's ability to provide adequate care is the predominant criteria in admitting, or not admitting, a resident with a known communicable disease or infection. Procedure: 1. Upon admission, the resident will be assess for: ...b. Pneumococcal vaccine status, by history..." (B)	S9999		