STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006282	A. BUILDING: _____ B. WING _____	C 03/19/2025

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LOFT REHAB OF ROCK SPRINGS, THE	2530 NORTH MONROE STREET DECATUR, IL 62526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of 02/18/25/IL187725	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) 300.1210b) 300.1210d)1)2) 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. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		

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S9999	Continued From page 1 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to implement a physician order "STAT" (immediate) for orthopedic consult appointment, in a timely manner, for a resident (R1) with a right Humerus fracture. This failure resulted in a six day delay, which caused severe pain and swelling before the application of a cast could occur. This failure affected one of three residents (R1) reviewed for falls/physician orders on the sample list of six. Findings include: R1's Minimum Data Set (MDS) dated 01/15/25 documents the following: Brief Interview of Mental Status (BIMS) score of 15, out of a possible 15, indicating no cognitive impairment.	S9999		

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R1's Health Status Note dated 2/18/25 at 11:05 am, signed by V21, Licensed Practical Nurse (LPN) documents the following: "Note Text: Writer approached by CNA (Certified Nursing Assistant) stating that on the way to the bathroom resident had trouble pulling her legs forward and fell to her knees. Writer performed full body assessment. Resident able to move all extremities but did c/o (complained of) pain to her R (right) arm during this assessment. Resident denied pain anywhere else." The same Health Status Note documents "Writer notified MD (Physician), resident (R1) notified her emergency contact."

R1's Health Status Note dated 2/18/2025 at 1:54 pm, documents the following:
"Note Text: Resident assessed by NP (V22, Facility, Nurse Practitioner) after fall. STAT (immediately) X- rays ordered for Right Elbow and Forearm."

R1's "Medical Practitioner Note (Physician/Nurse Practitioner)" Note dated 2/19/2025 at 3:15 pm, with the date of service as 02/18/25 (the day of R1's fall), (unknown time) documents the following: R1 was assessed by V22, NP for a complaint of right elbow pain rating her pain intensity as eight out of ten (severe). The same report documents swelling in R1's right elbow, with moving it makes it worse, rest make it better. "Tylenol (analgesic pain medication) is not making it better." The same note documents: "Right elbow pain -- Will start Tramadol for pain 50 mg PRN".

R1's Health Status Note dated 2/18/2025 at 1:55 pm, documents the following:
"Note Text: Resident c/o pain NP (V22, Nurse Practitioner) made aware NO (new order) rec'd (received) for Tramadol (Tramadol, narcotic pain

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medication) q (every) 12hrs (twelve hours), PRN (as needed)."

R1's X-Ray results dated 2/18/25 at 9:48 pm documents the following:
"PROCEDURE: ELBOW 2V (views)
Interpretation:
Reason for Study: Acute Pain Due to Trauma.
Elbow 2V, right.
FINDINGS: Acute transverse fracture involving right humeral condyles with modest displacement. There is associated joint effusion.
CONCLUSION: Acute transverse fracture involving right humeral condyles with modest displacement."

R1's Health Status Note dated 2/19/2025 at 00:30 am documents: "Note Text:
(V8, Medical Director/Physician) notified of res (R1's) X-ray results at this time."

R1's Health Status Note dated 2/19/2025 at 05:22 am documents the following:
" Note Text: N.O. rec'd per MD to send to Orthopedic Stat (immediately) for rt arm fx (fracture). Res cont (continues) fall status. Res c/o (complained of) pain. N. O's rec'd to increase Tramadol (50 milligrams) to q 4hrs PRN for pain, and ice packs to Rt elbow q 4hrs."

R1's Health Status Note dated 2/19/2025 at 11:34 am documents: "Note Text: called and spoke with (V30, Orthopedic Office Staff) DOC (Local Orthopedic Center) and resident has appt (appointment) on 2/24/2025 at 1:45 pm for f/u (follow up) with RT elbow fracture." This appointment was not a follow-up appointment, this was the initial appointment. This was not the physician ordered STAT (immediate) appointment, post- fall 2/18/25.

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R1's Health Status Note dated 2/20/2025 at 1:28 pm documents the following: Note Text:
(V8, Medical Director) gave N.O. for sling to right upper extremity r/t (related to the) fall.

R1's "Controlled Drug Receipt/Record/Disposition /Form" count sheet documents R1 was administered 12 doses of Tramadol HCL, 50 milligram tablet used for moderate to severe pain, between 2/19/25 and 2/24/25 while waiting for her initial appointment with the Orthopedic Center on 2/24/25.

R1' February 1-28, 2025 Medication Administration Record does not document R1 was administered R1's available Tylenol 1000 mg, every four hours for mild pain.

R1's "(Local) Orthopedic Center, Encounter Date" report dated 2/24/25 and signed by V20, Orthopedic Nurse Practitioner documents the following: "History of Present Illness:
The patient (R1) is a (specific age) female who presents for an evaluation of elbow pain. She states that she fell a week ago on 02/18/2025. She landed directly on her right elbow. She states that she has been in severe pain ever since. She had X-rays done at her nursing home (the facility) that revealed a fracture in her elbow. She states that they have been icing it, and they put her on pain meds. These have given her moderate relief. However, whenever she moves her right arm, she has severe pain. She has her right arm in a sling. She has very noticeable swelling in her right arm compared to her left arm."

The same report documents: "Assessment & Plan, Fracture of Humerus, distal, right, closed. Today's Impression: (R1) is a (specific aged)

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female who presents today for evaluation of right elbow pain. She fell sustaining a distal Humerus fracture nearly one week ago. Her x-rays from today confirm a displaced, distal Humerus fracture. I discussed her treatment options. The patient has a multitude of risk factors upon consideration for surgery. The patient is morbidly obese as well as diabetic. We discussed that this could put her at increased risk for infection and delayed wound healing. The patient also uses a walker for assistance with ambulation at baseline. I discussed my concern that her hardware could easily be removed if she is putting all of her weight through her upper extremities when she is ambulating with a walker. Because of these multiple factors, I think it is best to treat this patient conservatively. She verbalized understanding and is agreeable with this. At today's visit, we placed the patient into a posterior splint. I would like for her to work on hand and finger range of motion of at the (facility). I would also like the (facility) to aggressively ice. I am hopeful these things will help her swelling. I would like to see her back in two weeks for re-evaluation."

The same Report documents: "Application of Long Arm Splint Routine" and "Cast Supplies, Long Arm Cast Plaster, Routine."

On 3/13/25 at 3:20 pm R1 was lying in bed watching television. R1 had a cast on her full right arm, and a faint fading bruise on the right side of her nose caused by the fall 2/18/25. R1 stated, "They did an X-ray later that day (2/18/25). I did not get the results until the next day. I don't know why I wasn't sent to the emergency room. I don't know why there was a delay in getting an appointment to see the doctor in the orthopedics department. At first, I did not know I had a

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fracture. I just knew my arm hurt a hell of a lot, every time I moved it. I tried to keep it still to keep my pain level down. It was twelve, on the scale of one to ten when I moved it. The pain never went away. I tried to keep my arm elevated on a pillow and placed ice on it, to reduce the swelling. It is hard to keep it still, if you can even get to sleep. The pain would wake me several times a night, before I got this cast. I consistently received a pain pill which helped very little with the pain. A couple days later, someone brought in a sling. I did not like the sling; it did not fit right or something. It made my arm pain worse. My arm was more comfortable without it (arm sling) on, if I kept it elevated and kept taking the pain medication. My arm had really swelled up over the next couple of days. I thought that person (unidentified) was going to bring in a larger one (sling) that fit. That did not happen. Several more days past, I ended up with this cast (full right arm cast). My pain went down from an average of seven or eight to a two or a three once, I got the cast. I still take the pain medications. Between the cast and the pain pill, I am relatively comfortable. Not pain free that is for sure. I have not been out of my bed except for the doctor's appointments. It is not worth it. I am somewhat comfortable now and want to stay that way while my arm heals. The CNA's (unidentified) have been washing me up in bed, so I don't have to get up."

On 3/14/25 at 1:15 pm V2, Director of Nursing (DON) confirmed after V8, Physician reviewed R1's X-ray, V8, Physician gave R1's STAT order for R1 to be seen by Orthopedic Specialist. V2 stated, "The Orthopedic office gave (R1) their first available appointment 2/24/25. (R1) should have been seen right away. I assumed the Ortho (Orthopedic Center) office knew this was a STAT

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order. I can see now the progress note documents this was a follow-up, but it was the first time (R1) was seeing them for her arm fracture. I guess we really should have let (V8, Physician) know they (Orthopedic Center) couldn't get her (R1) in until the 24th. He may have sent her to the ER (Hospital, Emergency Room) had he known it would be that long (six days). (R1) has had a lot of pain. We had her Tramadol increased. She had a lot of pain and swelling in her arm, as you can imagine. Once she got the cast on at that appointment (2/24/25) she has finally had some relief from the pain."

On 3/14/25 at 2:10 pm V20, Orthopedic Office Nurse Practitioner (NP) stated V20 had seen R1 for the first time on 2/24/25. V20, NP stated she was "very frustrated" when R1 came to V20's Orthopedic Center on 2/24/25, because R1's fractured arm was not positioned well in a sling. There was nothing to stabilize (R1's) arm and prevent the possibility of further damage. V20, Nurse Practitioner stated, "(R1) had a significant displaced Humerus fracture. (R1) should have gone immediately to the Emergency Room (ER) after she fell." V20, NP stated the Orthopedic office had not been told of the Stat (immediate) order to be seen by us (Orthopedic Specialist), instead of waiting six days for the appointment. The office protocol for a STAT consult, is to have the X-ray sent to the office immediately for review and not wait for the first available appointment. (R1) had a significant displaced fracture. I would have reviewed the X-ray and sent (R1) to ER (Emergency Room), immediately." V20, Orthopedic Nurse Practitioner confirmed the facility caused the delay in treatment, by failing to follow the STAT (immediate) referral for Orthopedic treatment. This failure resulted in a six day delay without a properly placed sling to

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prevent further damage. V20 stated, "(R1's) arm was extremely swollen by the time I (V20, Orthopedic Nurse Practitioner) saw her (R1). She was in a lot a pain. How in the world did this situation slip through the cracks. They (the facility) knew she had fallen, and the X-ray showed the immediate need for treatment. She should have gone to ER."

On 3/18/25 at 2:30 pm V8, Physician/Medical Director (MD) stated the facility should have known to call V8, if an appointment was not available until six days after R1 fell and fractured R1's right Humerus on 2/18/25. V8, MD stated R1 was not a good candidate for surgery with all R1's comorbidities. V8, MD was confident the sling would be effective to maintain stability of R1's fractured arm. V8, MD stated the swelling and pain would be the only complication, in waiting for the Orthopedic consult. V8, MD stated V8, MD had to increase R1's Tramadol to maintain R1 comfort while R1 waited for that appointment 2/24/25.
(A)

Statement of Licensure Violations (2 of 2):

300.610a)
300.1210b)
300.1210c)
300.1210d)6)
300.1220b)3)
300.3100d)7)

Section 300.610 Resident Care Policies

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S9999	Continued From page 9 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. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.	S9999		

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S9999	Continued From page 10 300.1220 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. Section 300.3100 General Building Requirements d) Doors and Windows 7) Thresholds or parting strips in doorways used by residents shall be flush with the floor. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to provide a safe environment and implement fall interventions which resulted in R3 falling out of bed and hitting her head on the bedside dresser on two separate occasions, both required emergency medical attention for head lacerations requiring closer with staples. The facility also failed to provide adequate assistance and a safe environment during resident ambulation, resulting in R1	S9999		

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sustaining a right arm fracture. These failures affected two of three residents (R1, R3) reviewed for falls on the sample list of six.

Findings Include:

1. R3's Medical Diagnosis List dated March 2025 documents R3 is diagnosed with Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left non-dominate side, Restlessness and Agitation, Anxiety, Restless Leg Syndrome, and Insomnia.

R3's Minimum Data Set dated 11/21/24 documents R3 is cognitively intact and requires moderate assistance from staff for safe transfers. R3 is wheelchair bound.

R3's State Report dated 2/24/25 documents on 2/24/25 R3 rolled out of bed and hit her head on the bedside dresser, sustaining a head laceration. R3 was sent to the Emergency Room where the laceration was closed with five staples.

R3's Post Fall Evaluation dated 2/25/25 documents on 2/24/25 R3 was found lying on the floor beside her bed with her head against the bedside dresser. R3 had rolled from her bed onto the floor. R3 sustained a laceration to the back of her head and was sent to the Emergency Room where she received five staples to close the laceration. Contributing factors related to the fall and subsequent injury are documented as no floor mats in place, poor lighting, and bed was at an improper height.

R3's Fall Interdisciplinary Team Note dated 2/25/25 documents on 2/24/25 R3 was found on the floor in her room beside her bed. R3 stated she was reaching for something and rolled onto

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the floor. R3 sustained a laceration to the back of her head, went to the Emergency Room and received five staples to the laceration for closure. It was determined that R3 hit her head on the bedside dresser when she rolled out of bed. New interventions regarding the fall include to ensure frequently used items are within easy reach and to modify the furniture layout in the room for safety.

R3's Hospital Records dated 2/4/25 document R3 was seen in the Emergency Room for laceration to the back of her head after a fall to the floor which required five staples to close.

R3's State Report dated 3/2/25 documents on 3/2/25 R3 again hit her head on the bedside dresser and sustained another head laceration. R3 was sent to the Emergency Room where this time the laceration was closed with four staples. R3 stated upon returning to the facility that she hit her head on the corner of the bedside dresser when she laid back in bed. New interventions regarding the R3's safety include to pad the corners of the bedside dresser and place two assist rails on R3's bed.

R3's Emergency Department records dated 3/2/25 document R3 was seen in the Emergency Room after hitting her head and sustaining a laceration to the left side of her head requiring four staples for closure.

R3's Care Plan last updated on 3/2/25 documents R3 is at risk for falls due to her medical conditions and requires staff assistance with transfers. The same Care Plan documents the following fall interventions for R3: Scooped mattress to help identify bed parameters, fall mats when in bed, call light extension cord, ensure frequently used

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items are within easy reach, modify furniture for safety, place bed in the lowest position, and pad the corners of the bedside dresser (nightstand), etc.

On 3/14/25 at 12:30 PM V14 Licensed Practical Nurse (LPN) stated she was the nurse for R3 when she was injured on 3/2/25. V14 LPN stated she was aware R3 had hit her head on the bedside dresser previously on 2/24/25 and after that fall, the bedside dresser was moved and kept away from R3's bed. Instead, it was on the wall close to the door. V14 stated she in not sure who moved the dresser but when she observed R3's head bleeding on 3/2/25 the bedside dresser was positioned right up next to R3's bed. V14 stated other interventions not in place were the scoop mattress and R3's bed was not in the lowest position. V14 stated R3 has fallen out of bed and from her wheelchair many times and has poor safety awareness. V14 LPN confirmed if the bedside dresser would have been kept away from R3's bed like it was supposed to be, R3 would not have hit her head on the bedside dresser causing a laceration.

On 3/13/25 at 3:45 PM R3 was lying in bed. There was no scoop mattress on the bed, no call light extension cord in place, no padding on the bedside dresser, and the dresser was close to R3's head of bed. R3 stated she has never had a scoop mattress or call light extension cord. R3 stated at the time of her fall on 2/24/25 her bed was not at its lowest position and fall mats were not in place. R3 stated on 3/2/25 she went to lay back in her bed and she hit her head on the bedside dresser. R3 stated she is not sure who moved the dresser back to beside her bed, but she knew they had previously moved it away for her safety.

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On 3/14/25 at 1:45 PM V2 Director of Nurses confirmed R3 is a very big fall risk due to her unsafe ability to get up on her own, he medical diagnoses, her poor safety awareness, and her resistance to asking for help. V2 stated on 2/24/25 when R3 rolled out of bed, there should have been a scoop mattress on the bed, fall mats on the floor, bed at the lowest position, and a call light extension in place. V2 confirmed when R3 rolled out of bed she sustained a right head laceration which required five staples to close. V2 stated after the 2/24/25 fall, R3's bedside dresser was to be moved and kept away from her bedside and placed towards to door. V2 confirmed on 3/2/25, R3's bedside dresser was somehow moved back next to the head of R3's bed. V2 is unsure of who moved the dresser back but stated they in-serviced all staff to not move residents' furniture around without verifying it is not a safety/fall intervention. V2 confirmed on 3/2/25, R3 laid back in bed and hit her head on the corner of the bedside dresser, sustaining a head laceration which required four staples to close. V2 stated all R3's fall/safety interventions should be in place at all times. Staff should be aware of what they are and ensure they are in place to prevent falls or injuries.

The facility's Fall policy 2/12/25 documents, "each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Staff are to implement universal environmental interventions that decrease the risk of resident falling, including, but not limited to clear pathway to the bathroom and bedroom doors, bed is locked and lowered to a level that allows the resident's feet to be flat on the floor when the resident is sitting on the edge of the bed. Bed should always be in low position when

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the resident is sleeping, call light and frequently used items are within reach and adequate lighting."

2). R1's multi-dated Diagnoses Sheet documents the following: Weakness, Cellulitis of Left Lower Limb, Cellulitis of Right Lower Limb, Essential (Primary) Hypertension, Paroxysmal Atrial Fibrillation, Anemia in Chronic Kidney Disease, Diabetes Mellitus Type II with Hyperosmolarity With Coma, and Body Mass Index 45.0-49.9, Adult (Morbid Obesity).

R1's Minimum Data Set (MDS) dated 01/15/25 documents the following: Brief Interview of Mental Status (BIMS) score of 15, out of a possible 15, indicating no cognitive impairment.
The same MDS documents R1 requires substantial to maximum assist with toileting, is dependent on staff positioning, and had no impairment of the upper or lower extremities range of motion.

R1's "Witnessed Fall" report dated 2/18/25, signed by V21, Licensed Practical Nurse (LPN) documents R1 was ambulatory with assistance.
"Nursing Description: Writer approached by CNA (Certified Nursing Assistant/unidentified) stating that on the way to the bathroom resident had trouble pulling her legs forward and fell to her knees.
Resident Description: Resident stated that her leg wouldn't move as she was walking to the bathroom, and she went down.
Immediate Action Taken Description: Writer performed full body assessment. Resident able to move all extremities but did c/o (complained of) pain to her R (right) arm during this assessment. Resident denied pain anywhere else. Writer

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obtained vital signs b/p (blood pressure): 153/97, P (pulse) :94 R (respirations) :18 T (temperature):97.9. Writer then assisted two CNA's with a (full-body mechanical) lift to get resident off of the floor and into the bed. Writer notified MD (Physician) resident (R1) notified her emergency contact."
"Predisposing Environmental Factors: None (observation and interviews documented below identified there was a damaged, metal, sharp threshold strip that caused R1's foot to get stuck)
"Predisposing Physiological Factors: Gait imbalance and recent illness."
"Predisposing Situation Factors: Ambulating with assist during transfer, standing and using walker."
V13, Certified Nursing Assistants (CNA) statement as follows: "I was walking resident (R1) to the bathroom and resident foot got stuck. Resident fell to the floor on her side and sat back up on her bottom, writer called for help and nurse (V21, LPN) and CNA came. Nurse did full body assessment and we obtained vitals. We then use (full-body mechanical lift) lift and got resident off the floor and into the bed.

The facility "State Report" prepared by V1, Administrator, documents R1's fall incident occurred on 02/18/25. The same report documents the following: "BRIEF DESCRIPTION OF INCIDENT: Resident had witnessed fall going to bathroom. Resident c/o (complained of) pain to right shoulder and antecubital space. X-Ray ordered to Rt. (right) Elbow and Rt. Forearm. XR(X-Ray) results stated acute transverse fracture involving rt. Humeral condyles with modest displacement." R1's fall investigation results as follows: "Summary of the Investigation: At 09:36 (a.m.), 02-18-25 resident (R1) was observed falling to the ground landing on her right side. Resident stated her leg wouldn't move as

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she was walking to her bathroom, and she went down. Staff stated her foot got stuck causing resident to go down on her right side. Resident c/o (complained of) right extremity pain mainly in right antecubital space. Residents' pain was managed with Tramadol (narcotic, pain medication). Portable X-ray was done in facility and MD (Physician) ordered to see Ortho (Orthopedic Specialist). Resident saw Ortho on 2-24-25. Resident has soft cast in place on Right arm. Plan of care was updated."

R1's X-Ray results dated 2/18/25 at 9:48 pm documents the following:
"PROCEDURE: ELBOW 2V (views)
Interpretation:
Reason for Study: Acute Pain Due to Trauma.
Elbow 2V, right.
FINDINGS: Acute transverse fracture involving right humeral condyles with modest displacement. There is associated joint effusion.
CONCLUSION: Acute transverse fracture involving right humeral condyles with modest displacement."

On 3/13/25 at 11:05 am R1 was asleep in bed with a cast on her full right arm. R1 also has R1's bilateral lower legs wrapped in compression type wraps.

On 3/13/25 at 3:20 pm R1 was lying in bed watching television. R1 had a cast on her full right arm, and a faint fading bruise on the right side of her nose. R1 stated, "The day I fell (2/18/25), someone I did not know (later identified as V13, Certified Nursing Assistant), answered my call light and walked me to the bathroom. I think it was a nurse, but it might have been a CNA (later identified as V13, Certified Nursing Assistant). That day was the only time I ever saw that girl.

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She did not use a gait belt like the other CNA do. I was using my walker. She just walked beside me and did not do anything to try to keep me stable. I am weak and it is obvious. My left legs always have these bandages on them. I was wearing my slippers the day I fell. As I walked through the bathroom door my left foot got struck on the raised, sharp part of the metal strip across the doorway floor." R1 pointed towards the bathroom. The damaged metal strip could be seen from R1's bed. This surveyor observed the quarter inch metal strip threshold adjoining the bathroom floor and bedroom floor. Six inches from the left side of the bathroom open doorway was a sharp bent section of metal sticking up. R1 stated, "I asked that girl (V13, CNA) to help me get it loose, maybe lift my foot or bump it a little with her foot. That girl told me 'You will have to do it; I can't I am pregnant.' I tried and could not get it to move. I tried several times, for several minutes, I could not get the strip to release my house shoe. I was feeling weak from trying on my own. I lost my balance, and my right knee gave out. I did not feel this was abuse. I did feel this was an unnecessary fall. Had one of my routine CNA's been helping me, they would have done everything they could to keep me from falling. They would have had to bump my foot or pull it up off that strip. Almost every time I go to the bathroom, my foot gets caught there. I went down, hitting my face my walker and the whole right side of my body on the floor. It could have been prevented if she (V13, CNA) had even tried to break my fall. Since I did not have on a gait belt, she did nothing to break my fall or catch me. I get she was pregnant, but it was not safe for her to help me alone."

On 3/14/25 at 11:25 am V13, Certified Nursing Assistant (CNA) confirmed she was with R1 when

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R1 fell. V13 stated, "It was the first time I had taken care of (R1). (R1) used a walker to get to the bathroom. I was standing close to her while she walked. (R1) barely lifted her feet, took small steps, and kind of slid her feet across the floor on the way to the bathroom. (R1) was not able to lift her feet or slide her feet very well when we got to the bathroom doorway. I usually have a gait belt on residents when I walk with them (residents). I can't remember if I put a gait belt on (R1) or not. I am pretty sure I did. I am not positive, but I know we are supposed to (use a gait belt). (R1) asked me to scoot her foot for her, because it was stuck on the metal (threshold strip) in the doorway. I could not bend over, because I am pregnant. I told her to keep trying on her own. I did not know what to do. I couldn't reach the bathroom call light because her walker took up the whole doorway. I held on to the walker thinking that might help. She kept trying (to un-stick her shoe from the metal strip), several times and said she was getting worn out. I did not want to leave her, so I just kept holding onto her walker. (R1), all of the sudden, lost her balance and fell hard to the right. I couldn't help her because she weighs a lot. I am pregnant and have to be careful. She hit her face on the walker, and then hit her body on the floor. I went for help right away. (V17, CNA) and (V18, CNA) came right away. Then a nurse (unidentified) came in. I felt bad, but I couldn't stop the fall. After the nurse (later identified as V21, Licensed Practical Nurse) did an evaluation, they (V17, V18, CNA's and the nurse) used the (full body mechanical lift) to get her off the floor and back in bed. (R1) said her arm was hurting her really badly. I heard later her arm was fractured from the fall. I felt awful that I could not stop her from falling."

On 3/14/25 at 11:50 am V17, Certified Nursing

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Assistant (CNA) stated, "I take care for (R1) frequently. R1 has been weaker since she readmitted from the hospital in January. We can't get her wheelchair into the bathroom. The bathroom is too small. (R1) walks with a walker, real slow, because of the cellulitis in her legs and her increased weakness. She should not be rushed. I always use a gait belt. We are supposed to (use a gait belt) with all residents. (V13, CNA) did not have a gait belt on (R1) when she (R1) fell. I was here, I went in to help immediately, and I helped transfer her right after the fall. (R1) did not have a gait belt on. We used the (full-body mechanical lift) to get her off the floor. (R1) was in a lot of pain. She said it was in her right arm. Her (R1's) face was already starting to bruise a little by her nose. She said she hit her face on the walker on her way down to the floor. (V13, CNA) is big and pregnant. She did not know (R1) needed a little help to move her foot over the metal strip. I usually just give her shoe a little nudge. That metal strip has a sharp edge, and it is right where you have to walk in there. It does not take much to un-stick her house shoe. It does not always get stuck, but it happens often. She (R1) asks for help if she is having a hard time lifting or sliding over the strip in the doorway. It only takes a second to give her shoe a nudge."

On 3/14/25 at 1:15 pm V2, Director of Nursing (DON) confirmed V13, Certified Nursing Assistant was the CNA who assisted R1 to the bathroom when R1 fell. V2 stated V2, DON had not been informed R1 asked V13 to raise R1's foot or scoot it over a damaged strip on the floor. V2 also stated she was not aware V13 did not use a gait belt for R1's transfer to the bathroom, 'as she should have'.

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S9999	Continued From page 21 On 3/18/25 at 11:25 am V21, LPN confirmed V21, LPN was R1s nurse on 2/18/25 when R1 fell. V21 stated, "I don't remember (R1) having the gait belt on when she fell. I would have documented it, had one been on. I helped the CNA's transfer (R1) back to bed. We used the (full -body mechanical lift). (V13, CNA) is pregnant. Had I known she could not adequately assist (R1), I would not have had (R1) on (V13, CNA's) list. We change assignments for a variety of reasons. (R1) should have had on a gait belt and should have been provided full assistance to the bathroom." V21, LPN stated, "I did not see that she hit her face on the walker, and I did not realize R1's foot was stuck on the metal strip in the doorway. I was focused on getting her comfortable and calling the provider for an X-ray (order)." On 3/18/25 at 12:00 pm V18, CNA stated, "(R1's) fall I can tell you that strip in her bathroom door has been a problem. Even the (mechanical stand lift) and wheelchairs get stuck on the rough edges of that thing (metal threshold strip). (R1's) foot gets stuck all the time and I either bend over or give her foot a little nudge. (V13, Certified Nursing Assistant) does not usually have that group. (V13, CNA) is also eight months pregnant. She did not know her (R1). I know (R1) can't stand very long. She leans on her walker after a couple minutes, (R1's) legs would give out. (V13, CNA) probably did not realize that. She (R1) will tell you is she is feeling weak. Knowing (R1), I am sure she told (V13, CNA that. We are supposed to wear gait belts with all transfers. I don't recall if (R1) had one or not. I don't remember seeing one. We were all rushing around trying to figure out how we would get (R1) off the floor. I may have just missed it (seeing the gait belt). I would do anything to prevent a resident from falling.	S9999		

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Gait belts help stabilize people. Putting on the call light if we need extra help makes the most sense. (V13, CNA) probably couldn't fit through the bathroom doorway, to turn on the call light and ask somebody else for help. From seeing (R1) on the floor in the bathroom, I can see how (V13, CNA) would have a problem turning on the call light. (R1) is a large woman, her walker is pretty big, (V13, CNA) is big pregnant, and the bathroom is very small."

On 3/19/25 at 8:58 am V26, Maintenance Director entered R1's room to assess the metal threshold strip in R1's bathroom doorway. R1 stated she was glad to see V26 is going to fix her walking path to the bathroom. Though R1 has not been out bed since her fall, she fully intends to be up and around as her therapy is going to make her strong enough to go home. She will be using that bathroom soon, she hopes. V26 swiped the metal strip and stated, "It is rough and has a sharp edge. I will replace this with a rubber strip. Had I known it needed repair I would have already done it. I usually hear about issues in morning meeting. No one said anything. The staff also know they just need to let me know throughout the day as things come up. I'm here and make myself available right away if it is a safety issue like this."

R1 stated once she starts getting out of bed and walking, she 'will have some peace about going into the bathroom'. R1 stated she is getting her leg dressings changed this morning and surveyor can observe.

On 3/14/25 at 2:10 pm V 20 Orthopedic Office, Nurse Practitioner (NP) stated R1 is alert and oriented and had given the fall details to V20, NP at the appointment with V20, NP on 2/24/25. V20

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S9999	Continued From page 23 stated, "(R1) told (V20) she needed assistance from the staff member to lift her foot over a strip on the floor, and did not receive assistance, which resulted in the fall. It sounded like this fall, that caused (R1's) fracture (right Humerus), could have been prevented had she received the assistance she needed." (A)	S9999		