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S 000	Initial Comments Annual Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210b) 300.1210d)6) 300.1210c) 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 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. 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 regulations were not met as evidence by: Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision for residents at high risk for falls and failed to implementing interventions for a resident with wandering behaviors. This failure applied to three of five residents (R52, R56, and R61) reviewed for falls and resulted in R52 sustaining a right hip fracture and a head injury requiring medical treatment.	S9999		

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Findings include:

Per the facility's incident log from 09/01/2024 - 03/24/2025 the facility has had 73 unwitnessed falls with 18 of them involving memory care residents, R52 had a fall each month from December 2024 - March 2025 with two of them being unwitnessed, and R61 had four falls within three weeks of admission with three of them being unwitnessed.

1. R52 is a 79-year-old female with a diagnosis's history of Dementia with Behavioral Disturbance, Anxiety Disorder, Age Related Cataracts, and Stroke who was admitted to the facility 02/06/2019.

The facility's incident log from 09/01/2024 - 03/24/2025 documents R52 had a witnessed fall on 12/18/2024 at 9:13 AM, and unwitnessed falls on 01/12/2025 at 4:30 AM, and on 02/09/2025 at 6:55 AM

Per the facility's reportable event log received 03/24/2025 R52 had a fall on 12/18/2024 that resulted in a right hip fracture and a fall on 01/12/2025 that resulted in a laceration of her head.

R52's quarterly minimum data set dated 09/27/2024 documents she requires supervision or touching assistance for walking 10-150 ft.

R56's fall risk assessments dated 12/18/2024 and 12/24/2024 documents she is at high risk for falls.

R52's current care plan created 02/18/2019 documents she exhibits behavioral symptoms as evidenced by wandering and at times can be

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difficult to redirect and unaware of her safety needs with an intervention implemented 02/18/2029 of approaching/speaking in a calm manner and an intervention implemented 05/17/2019 of walking with R52 when she is wandering to ensure safety. R52's current care plan created 04/20/2019 documents she is at risk for falls related to diagnosis of dementia, confusion, poor communication/comprehension, poor safety awareness, wandering, and behaviors of feeling around door joints and attempting to open the door and leave the unit with intervention implemented 04/20/2019 including follow facility fall protocol, interventions implemented 03/21/2024 including staff to assist her in the dining room when meals are ready, allow her more sleep instead of having her wait in the dining room for meals; and intervention implemented 02/09/2025 of ensuring there is adequate supervision in the dining room. R52's current care plan created 12/19/2024 documents she has had an actual fall on 12/18/2024 which resulted in a fracture with interventions including staff checking her location and activity to ensure if she is properly and safely positioned in bed or chair/wheelchair. R52's current care plan initiated 01/12/2025 documents she had a fall on 01/12/2025 which resulted in a laceration on her left temple.

Fall Risk Management report dated 12/18/2024 documents R52 was observed walking down the hall after breakfast towards the door and when she was getting close by the door the nurse called her trying to redirect her and she turned around quickly, lost her balance and fell landing on the right side of her hip.

The facility's reportable event investigation report dated 12/19/2024 documents on 12/18/2024 R52

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was observed walking towards the door and when she was getting close to it, the nurse called her and tried to redirect her, she turned around quickly, lost her balance, had a change in plain and was sent to the emergency room for further evaluation and treatment and was admitted with a right hip fracture.

Fall Risk Management report dated 01/12/2025 documents at 4:30 PM R52 was found on the floor with a laceration on her head and was bleeding, while V20 (Nurse) was passing medications with her cart she turned around for a second and the next thing she heard behind her was the sound of a fall; contributing factors to R52's fall included confusion, impulsiveness, need for two person assistance with transfers, history of falls, observations of attempts at getting up without assistance recently, recently having surgery on her right hip, and diagnosis of fracture of right lower leg.

R52's hospital discharge report dated 01/12/2025 documents she was diagnosed with a closed head injury, and scalp laceration and received laceration repair.

The facility's reportable event investigation report dated 01/18/2025 documents R52 had an unwitnessed fall at approximately 4:40 PM on 01/12/2025 and sustained an approximately 3-centimeter laceration to her head, was sent to the emergency room for further evaluation and treatment and returned the same day to the facility with three staples to be removed in 7 days.

Fall Risk Management report dated 02/09/2025 documents R52 had an unwitnessed fall and was observed sitting on the floor in front of her wheelchair by the dining room with the root cause

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being losing her balance and falling when attempting to stand up from her wheelchair.

On 03/26/25 at 03:28 PM V18 (Restorative Nurse) stated he is the fall coordinator. V18 stated R52 has always been able to walk, and she fell on 12/18/2024 due to suddenly turning around. V18 stated R52 had a fall at 4:30 PM on 01/12/2025. V18 stated R52 was sitting in the dining room and trying to stand. V18 stated a nurse was present and tried to catch her but didn't make it in time. V18 stated he believes the nurse was administering medications at the time. V18 stated there are usually a lot of residents in the memory care dining room. V18 stated usually there are two aides in the dining room at mealtimes and at that time there was not two aides possibly due to passing trays. V18 stated at least two aides are needed in the dining room for proper supervision. V18 stated on 02/09/2025 R52 was near the dining room in her wheelchair and attempted to stand up and loss her balance and fell. V18 stated this was an unwitnessed fall so there weren't any staff present. V18 stated there should be some staff present to monitor residents.

On 03/27/2025 at 8:47 AM V2 (Director of Nursing) stated if there are several residents in the dining room, they would be sending more than one staff to supervise but it is not always their protocol to always assign and/or station two nurses or CNAs (Certified Nursing Assistant) at all times when residents are present in the dining room. V2 stated she understands that residents need supervision. V2 stated she was the one who conducted and completed the investigation after R52's fall incident and the nurse was by the dining room door beside her med cart where she can see the resident, but unfortunately, she

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wasn't able to get to the resident as fast as she could to prevent her fall.

On 03/27/2025 at 10:19 AM V2 (Director of Nursing) stated on 01/12/2025 when R52 had a fall there were 36 total residents in the memory care unit. V2 reported there are 12 residents in the memory care unit that are at high risk for falls. In response to the surveyor asking if a nurse is the only staff in the dining room with multiple residents on the memory care unit, and she is passing medications while someone is falling, doesn't that make it difficult to assist the resident who begins to fall or even monitor all the residents present in the dining room; V2 replied that on 01/12/2025 the CNA (Certified Nursing Assistant) was asked to assist another resident with toileting and a nurse was in the dining room to oversee the residents while the other was helping with bringing residents to the dining room for dinner.

On 03/27/25 at 03:03 PM V18 (Restorative Nurse) confirmed R52 and the nurse that witnessed her fall on 12/18/24 were inside the unit during the incident. V18 stated R52 and the other memory care residents usually roam around the memory care unit and wont usually attempt to leave and when they reach the exit door they turn back around. V18 stated if staff saw R52 approaching the memory care unit exit door they can monitor her to ensure she's ok and they usually just let the residents walk around. V18 stated in R52's particular situation on 12/18/2024 he can't think of anything the nurse could have done differently to prevent her fall because staff weren't expecting her to fall the way she did. V18 stated he doesn't think the nurse calling out to R52 could have startled her. V18 agreed the nurse was likely not close by R52 when she was

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approaching the door and therefore her voice calling out to R52 would not have been soft and low and agreed that the nurse would have had to call out to R52 loudly enough to be heard and get R52's attention. When asked by surveyor if the nurse could have just guided R52 away from the door rather than calling out to redirect her V18 could not provide any information.

2. R56 is a 90-year-old female with a diagnosis history of Alzheimer's, Dementia, Generalized Anxiety Disorder, Restlessness and Agitation who was admitted to the facility 04/12/2023.

The facility's incident log from 09/01/2024 - 03/24/2025 documents R56 had an unwitnessed fall 03/21/2025 at 5:15 PM

R56's current care plan created 04/25/2023 documents she is at risk for falls related to confusion, gait/balance problems, incontinence, poor communication/comprehension, and poor safety awareness with interventions implemented 04/25/2023 including follow facility fall protocol.

R56's quarterly fall assessment dated 01/09/2025 documents she is at high risk for falls.

Fall Risk Management report dated 03/21/2025 documents R56 had an unwitnessed fall and was observed sitting on the floor on her right-side by the dining room and the root cause of the fall being she most likely fell asleep in her wheelchair while waiting for dinner.

On 03/26/25 at 03:28 PM V18 (Restorative Nurse) stated according to the investigation of R56's fall on 03/21/2025 the nurse reported R56 fell asleep while sitting in her wheelchair and fell

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forward in the dining room. V18 stated this was an unwitnessed fall. V18 stated staff were likely passing trays and unable to catch R56.

On 03/27/2025 at 10:19 AM V2 (Director of Nursing) reported the facility does have enough staff to assist the residents in the dining room. V2 reported the facility usually has nursing and activity staff present in the dining room during meals. In response to surveyor asking should there be multiple staff in the memory care dining room during mealtimes or when multiple residents are present; V2 reported they usually have 2 Nurses, 3 CNAs and 1 Activity Aide to assist with the residents. In response to surveyor asking why should there be multiple staff present in the memory care dining room during meal times or when there are multiple residents; V2 responded they have nursing to assist with feeding the residents and activities assist with passing the trays and just rounding to make sure residents have what they need.

3. R61 is a 73-year-old male with a diagnosis history of Dementia with Behavioral Disturbance, Encephalopathy, and Depression who was admitted to the facility 02/10/2025.

On 03/24/25 at 10:57 AM Observed R61 in his room in his bed wearing a gown and protective sleeves over both his arms. Observed R61's right arm with multiple scabs and his right-hand knuckles with multiple scabs with dry blood sticking to the sleeve, a bruise, and a small bandage.

The Facility's incident log from 09/01/2024 - 03/24/2025 documents R61 had a witnessed fall on 03/04/2025 at 8:30 AM, and unwitnessed falls on 02/13/2025 at 5:11 AM, 02/22/2025 at 2:30

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PM, and 03/08/2025 at 11:05 AM.

R61's admission Fall Risk Assessment dated 02/10/2025 documents he is at high risk for fall.

R61's current care plan created 02/11/2025 documents he is at risk for falls related to generalized weakness, increased confusion, impaired cognition, altered mental status, and multiple medical conditions including activity intolerance and has exhibited behaviors of putting himself on the floor with intervention implemented 02/11/2025 of ensuring his call light is within reach and encouraging him to use it for assistance as needed, assessing and anticipating his personal needs and needs of activities of daily living such as toileting, incontinence care, eating etc. during rounds, ensuring he is centered in bed and bed bolsters are properly secured as appropriate and trunk and extremities are properly aligned and supported; intervention implemented 03/04/2025 of placing him in the dining room in the morning if he is observed up and awake if he will allow. R61's current care plan created 02/19/2025 documents he exhibits poor safety awareness and attempted to get out of chair/bed without staff monitoring and has difficulty comprehending redirection.

Fall Risk Management report dated 02/13/2025 documents R61 had an unwitnessed fall in his room and was observed laying on the floor on his right side with his head at the foot of the bed and mattress halfway off the bed and tilted; R61 reported he slid off the bed; Contributing factors include being admitted to facility due to fall and increased confusion, observed with agitation and confusion, and having diagnoses including pneumonia and altered mental status; Root causes of the fall include R61 moving on his bed

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and the mattress tilted and he slid off to the floor.

Fall Risk Management report dated 02/22/2025 documents R61 had an unwitnessed fall and was found on the floor in the hallway lying on his right side and his wheelchair behind him with the root cause being R61 making his way to the room from the dining room, wanting to go to the toilet, attempting to self-transfer without assistance, and losing his balance and falling.

Fall Risk Management report dated 03/04/2025 documents R61 had an unwitnessed fall in his room and was observed sitting on the floor and reported he put himself on the floor; he was observed to have small scratches on both his knees with the root cause including attempting to get out of bed.

Fall Risk Management report dated 03/08/2025 documents R61 had an unwitnessed fall and was observed lying on the floor on his right side by the hallway close to the nurses station and was observed with a bump on the right side of his forehead, skin discoloration, skin tears on multiple fingers on his left hand, skin tears on his right hand and right elbow and was sent to the emergency room for evaluation; R61 reporting he wheeled himself on his wheelchair and slipped from the wheelchair; the root cause of the fall includes R61 sliding down from his wheelchair.

On 03/26/25 at 03:28 PM V18 (Restorative Nurse) stated R61 is very impulsive and has had previous attempts to get out of bed on his own before falling 02/13/2025 and interventions for this would include low bed, floor mats, encourage toileting, offering to get him up in the wheelchair when already awake, offering activities, and trying to redirect him. V18 stated R61 needs frequent

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supervision and should be somewhere he can be monitored. V18 stated if R61 has been sitting in a place for a while he'll try to wheel himself somewhere. V18 stated R61's falls o 02/22 and 03/08 were due to him attempting to ambulate himself in the wheelchair and he will attempt to stand up. V18 stated interventions for this behavior is to have R61 close by staff for monitoring.

On 03/27/2025 at 1:34 PM in response to surveyor asking would lack of supervision or insufficient supervision cause of fall to be unavoidable; V2 (Director of Nursing) replied that the need for supervision or level of supervision is a factor, depending on the resident and a high-risk resident that is not adequately supervised is more likely to have a fall than a more mobile resident.

The facility's Fall Prevention and Management Policy received/reviewed 03/25/2025 states: "The facility is committed to its duty of care to residents and patients in reducing risk, the number and consequences of falls including those resulting in harm and ensuring that a safe patient environment is maintained."
"High-Risk Precautions will be implemented to residents and patients whose scores on Resident/Family Notification fall Risk screen shows high risk" with interventions including but not limited to "meaningful and or scheduled rounds."

(A)