

## Illinois State Department of Health

| <b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>                 |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><b>0055053</b>                                    |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br><b>06/23/2025</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><b>SOUTH HOLLAND MANOR HTH &amp; RHB</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2145 EAST 170TH STREET , SOUTH HOLLAND, Illinois, 60473</b> |  |  |   |
| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |  | (X5) COMPLETION DATE                            |
| S0000  | Initial Comments<br><br>Complaint Investigation 2595204/IL194121  | S0000   |  |  |   |
| S9999  | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br><br>300.690a)<br><br>300.690b)<br><br>300.690c)<br><br>300.1210b)5)<br><br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.690 Incidents and Accidents<br><br>a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. | S9999   |  |  |   |

Office of Primary Care and Health Systems Management

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| S9999  | <p>Continued from page 1</p> <p>b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.</p> <p>c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.</p> <p>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:</p> <p>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.</p> | S9999   |  |   |

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| S9999  | <p>Continued from page 2</p> <p>These requirements were NOT MET as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to follow two residents fall care plan and failed to transfer two residents (R1, R2) in a safe manner using a wheelchair and mechanical lift in a sample of three. These failures resulted in R1 sustaining an avoidable fall out of wheelchair and R2 sustaining a fall while using a mechanical lift resulting in R2 being sent to hospital due to constant headache, left hip, left elbow and left leg pain for three days.</p> <p>Findings include:</p> <p>R2 is a 58-year-old resident initially admitted to the facility on 3/21/2014 with diagnoses including but not limited to quadriplegia cervical 1-cervical 4 complete, anxiety disorder and spinal stenosis cervical.</p> <p>R2's Minimum Data Set (MDS) section C0500 dated 4/4/2025 documents Brief Interview for Mental Status (BIMS) score = 15 which suggests cognition is intact. MDS section GG0130 dated 4/4/2025 documents resident is dependent on staff for the following: eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene.</p> <p>R2's Fall Risk Observation form dated 4/7/2025 documents fall risk low with score of 9.</p> <p>On 6/16/2025, at 10:48 AM R2 stated I had a fall about 3 weeks ago it was a Friday. I was in the Mechanical lift and I ended up on the floor. The strap was not put right in the hook, I think. I hurt my elbow and my hip and my head. I went to the hospital Monday after the fall Friday due to the pain. They took x-rays and everything was ok. No injuries. I do not have any bruises any longer from it, but I did have. Only the left side unhooked. V6 CNA (Certified Nurse Assistant) and someone else (V8) were the CNAs that were here when it happened. They asked if I wanted to go to the hospital and I said not today.</p> <p>On 6/17/2025, at 10:49 AM R2 stated I had the fall with the Mechanical lift before Memorial Day that Friday. The lifts are not broken, they just did not hook it right that is what happened. I did have a lot of pain in my left elbow, left hip, and head. Pain level was 8/10 to head for 3 days. The elbow pain was about an 8/10. The hip did not have much pain at all. I had bruises to left elbow and left hip. The CNA name was (V6) the one that hooked up the loops to the machine.</p> | S9999   |  |   |

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| S9999  | <p>Continued from page 3</p> <p>At 10:55AM as surveyor was speaking with R2, V10 CNA and V11 CNA entered R2's room to help move R2 from bath bed to chair. Surveyor observed both CNAs place Mechanical lift pad and place R2 in lift. R2 stated he wanted black loop on legs and green on the top. Bar placed across chest. Mechanical lift legs were not opened to wide base while lifting R2 with mechanical lift. Legs of Mechanical lift was then opened slightly to lower resident in chair. R2 noted to instruct CNAs on Mechanical lift use every step of the way. V11 stated we are supposed to widen the legs of the lift prior to lowering the patient. When asked if needed to widen the legs to lift patient V11 stated there is no need to widen the legs to lift the patient from bath bed if the lift fits it fits. V10 CNA stated I was only aware of widening the legs of the lift when getting in front of chair to lower resident.</p> <p>R2's care plan dated 4/4/2024 documents focus: The resident is at risk for falls related to Deconditioning, Gait/balance problems, Paralysis.</p> <p>Goals: The resident will be free of minor injury through the review date.</p> <ul style="list-style-type: none"> <li>o The resident will not sustain serious injury through the review date.</li> </ul> <p>Interventions: Anticipate and meet the resident's needs.</p> <ul style="list-style-type: none"> <li>o Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.</li> <li>o Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility</li> <li>o ensure even weight distribution, when using H**** lift/sling (mechanical lift) d/t (due to) patient's spasms/quadruplegia</li> <li>o Follow facility fall protocol.</li> </ul> <p>On 6/16/2025, at 12:53 PM, V5 Licensed Practical Nurse (LPN) stated I was here the day R2 had a fall from the Mechanical lift. The CNAs were V8, and the other person was a restorative aide V6. So, I was sitting at the nurse's station charting and V6 CNA came by the door and waved for me to come here and R2 was on the floor in between the Mechanical legs. R2 was completely out of the sling on the floor. The Mechanical lift was like</p> | S9999   |  |   |

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| S9999  | <p>Continued from page 4</p> <p>halfway up/down like in the middle. I assessed R2. I helped get R2 back in the bed. I called V2 and the Doctor. The doctor asked if he was in pain. R2 had denied pain and did not want to be sent out to the hospital. A few days later I was R2's nurse again and he was complaining of pain, and I sent R2 out to hospital then and they did a full work up with no findings. I do not know how or why R2 fell out of the Mechanical lift. It makes no sense to me.</p> <p>R2's progress note dated 5/23/2025 documents: Note Text: Patient fell out of H**** lift (mechanical lift) during transfer.</p> <p>R2's incident report dated 5/23/2025 documents: witnessed fall. Resident description: resident stated they fell out of H**** lift (mechanical lift) during 2-person transfer.</p> <p>R2's skin assessments dated 5/27/2025, 5/30/2025 and 6/3/2025 show skin intact and no abnormalities marked.</p> <p>R2's hospital records dated 5/26/2025 document reason for visit: Fall. Imaging tests Computed Tomography (CT) cervical spine without contrast, CT head without contrast, X-ray elbow left 2 views, and x-ray hip left 2 views. CT head wo contrast results documents history: post traumatic headache. CT cervical spine wo contrast documents history: posttraumatic cervical spine pain. X-ray elbow left 2 views documents history: elbow pain. X-ray hip left 2 views results document history: posttraumatic left hip pain. ED (emergency department) triage notes documents: Patient comes to ED via EMS (emergency medical services) for a fall that occurred 3 days ago. Patient denies any LOC (loss of consciousness). Per patient, nursing staff was using a (mechanical lift) and dropped patient on his left side. Patient has a constant headache, left hip pain, and left leg pain. Pt denies any blood thinner at this time. ED (emergency department) provider notes documents: He experiences pain in his left elbow, hip and head following an incident where he was dropped from a (mechanical lift) at facility. the pain is localized to the left side, with specific mention of elbow and hip. He has difficulty with movement, expressing both 'I can move" and 'I can't move' indicating some level of immobility or discomfort. No changes in leg color were noted, as he confirms it is normal for him. ED Provider notes also document Fifty male with history of present illness above, differential includes acute traumatic injury versus sequelae.</p> <p>On 6/16/2025, at 1:10 PM, V6 (Restorative Aide/CNA)</p> | S9999   |  |   |

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| S9999  | <p>Continued from page 5</p> <p>stated I do recall working the day R2 had a fall from the Mechanical lift. So, I was going in there to assist the CNA (V8) to get R2 up. We did all of R2's ADL (activities of daily living) care, got R2 dressed and was getting R2 up to get in his chair and were using the Mechanical lift. R2 was very specific as to wanting the green straps (of Mechanical lift pad) at the top and the black straps at the bottom. This Mechanical lift we were using did not go up very high so the other CNA V8 (she no longer works here) was lowering the bed and holding R2's feet as I was pulling the Mechanical lift out. R2's body started tipping a little and when I was pulling R2 out V8 CNA had his feet and somehow some way the strap came out of the Mechanical lift, and I was able to grab it and lower R2 down to the floor so he did not hit so hard. R2 did hit his left elbow and left hip. We immediately asked him if he was ok he said yes. V8 CNA went and got the nurse V5 (LPN). V5 assessed R2 and asked if he was ok and he said yes and that he just hit his elbow on the Mechanical lift leg. R2 did not want to go out to the hospital and said he was fine. Myself, V8 CNA and V5 LPN got R2 back in bed. V5 LPN reported it to V2, Director of Nursing (DON). V2 came around and checked on R2 and he was fine. R2 wanted us to use the same Mechanical lift again to get him up and I told him I did not feel comfortable using that same Mechanical lift. It had to be a Mechanical lift malfunction. It seemed like one of the arms were loose or something. I am not sure if that same Mechanical lift is here or not. R2 did not get hurt because I was able to grab the Mechanical lift pad as it was going down so R2 did not hit as hard as he would have if I didn't. Surveyor went with V6 to look at Mechanical lifts in the building. Mechanical lift with outside company stickers and battery with no brand name has no safety clips but does not appear to initially have them. V6 stated the other Mechanical lift we used is similar to this one and I think the side hook was loose. Surveyor noted nut holding the side plate with hooks. Mechanical lift observed and did not have safety clips and area to put loops on was smaller. V6 stated I think they got rid of that Mechanical lift. V2 and upper management were looking at the Mechanical lifts after the incident and I think they tightened the bolt and got rid of that lift.</p> <p>On 6/16/2025, at 1:32 PM, V2 DON stated I was in my office with the ADON (Assistant DON) and restorative nurse having a meeting and V5 LPN came and said R2 had a fall from the Mechanical lift. We all went down there to see what had happened. So, I checked to see if R2 was ok. R2 said he was fine. I came back and spoke to R2 later that day when it was just him and R2 told me it was an accident, and I am fine. I called V15 Nurse</p> | S9999   |  |   |

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| S9999  | <p>Continued from page 6</p> <p>Consultant and me, the 2 CNAs (V6 and V8) and V15 Nurse Consultant went back to R2's room and connected him up to the same Mechanical lift they said they used. The aides claimed the Mechanical lift arm was loose, but I didn't think the arms were that loose. So, I took it (Mechanical lift) out of use sent it back to the company. I did have V13 (Maintenance Assistant) tighten up the nut on the arm just in case it got used before it got picked up from the company. V13 said it didn't tighten much but it did tighten some. Those arms are made to swivel. R2 did say what color loops he wanted where, and they hooked it up the same way they did earlier, and it did not sway how the girls (V6 and V8) said it did. One of the hooks from the head area had come undone and that is how he had fallen out. It was not one of the legs. R2 did not tell me that the CNA's did not hook it all the way. R2 complained that the bar on top wasn't wide enough on that Mechanical lift and that is why he was swinging. R2 kept telling me it was an accident. I also talked to him separately when the staff was not there so R2 could tell me anything confidentially. We also did education on staff on what Mechanical lift pads to use with the correct machine. The pad they used that day was the correct one for the correct lift. The one Mechanical lift that has the missing clips is a rented Mechanical lift and I am waiting for the company to pick it up. I needed it to lift a larger resident.</p> <p>On 6/16/2025, at 2:37 PM, V2 stated for the fall with the Mechanical lift for R2 the CNAs were V6 and V8. V8 resigned the day after the incident. V8 was upset when we were asking questions, I don't know if it scared her or what. My expectation of staff regarding things out of the ordinary happening is it should be reported. Proper lifting techniques, proper transfer techniques, etc. Once R2 fell they reported it right away. We as upper management were just making sure we are following our procedures. That is why I got V15 Nurse Consultant because it did not compute in my head how he could have had a fall from a Mechanical lift.</p> <p>On 6/16/2025, at 2:50 PM, V1 Administrator stated my expectation of staff regarding falls is to prevent falls as much as possible. Once a fall occurs is to call the nurse and have the nurse assess, ensure resident is ok and report to administration to investigate fall. My understanding of a reportable is that we report abuse, fall or injury especially an injury of unknown origin. I would not consider these two falls reportable. In R2's case in the initial reporting of the incident he was lowered to the floor when the sling was coming unloose. V6 said she got him and assisted to the floor, and he did not have any</p> | S9999   |  |   |

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| S9999  | <p>Continued from page 8</p> <p>moving R2's legs and V6 CNA started pulling the Mechanical lift and V6 seen the loop come off of the hook because the thing was swinging. R2's weight was swinging. R2 was not in the normal sitting position. It was not the right way; I knew it was not the right way. V6 seen that and tried to catch R2 in the Mechanical lift pad before he went to the floor. V6 was able to kind of catch R2 but R2 hit his shoulder and his hip on the floor. R2 hit his head on V6's foot. So, R2 did not fall as hard as he could have but R2 did fall. That is not even the first time they had an incident with this Mechanical lift. After this happened, they magically found another Mechanical lift that worked. R2 told me that the facility told them several times that they were not going to fix the (mechanical lift). I had not ever reported that Mechanical lift not working. That was the first time I had used that Mechanical lift. I usually used the other one, and that one worked. That day the battery would not charge on the other one. We could not find a battery that worked. I did not tell management about that prior to using the broken (mechanical lift). We told V2 after the fact about the battery not charging so he knew. What would have prevented this from happening would be if we would have had a different Mechanical lift or if the arms weren't loose and if we would have paid more attention to the state of the Mechanical lift before using it. The last time I was trained on the Mechanical lift was when I got hired around March. I always knew it was a 2-person job. If we see a fall or know of a fall, we are to report to the nurse right away.</p> <p>On 6/17/2025, at 11: 26 AM, V6 Restorative Aide/CNA stated, regarding the Mechanical lift used the day R2 had a fall, the Mechanical lift that we used that day, I was not aware of it being broken prior to us using. We looked for the Mechanical lift we normally used for R2 and could not find it. I did not notice prior to using the Mechanical lift that the arm was swinging more than it should have until he was in the sling. I was the one that hooked R2 up to the Mechanical lift that day. I did not and do not recall V8 telling R2 not to use the black and green loops for the Hoyer that day. There were 2 other Mechanical lifts here that day but did not have batteries to charge them. The batteries were dead. We had to plug them in. I do not know how long it normally takes to charge the batteries. I think they were the Mechanical lifts that they are renting. I do not think they came with any battery exchange. So, they only had the one it came with. V8 CNA no longer works here. V8 is my daughter. I don't know if V8 knew the lift was broke before I came in to help her. I did not know that it was broken prior to using it. I know R2 was adamant to get out of the</p> | S9999   |  |   |

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| S9999  | <p>Continued from page 9</p> <p>bed because he was in the bed for the 2 days prior from his preference. R2 still wanted to use the same Mechanical lift after the fall and I refused. We did end up finding the other Mechanical lift we normally use for him after the fact. In my opinion if they checked the Mechanical lift more often to see if they are working properly this would have not happened. And making sure they are charged pretty much that is it. I do not know how often they check the Mechanical lifts. If they are broken or not charging, we let V2 know and take down to maintenance door and they will look at it.</p> <p>On 6/17/2025, at 11:44 AM, V2 stated, on the floor we have four Mechanical lifts in the building. We had more but parts broke, they were old we had to pull them out. It costs less to buy a new Mechanical lift than to get them fixed. Regarding the CNA Mechanical lift transfer trainings they should be done annually. The records show the last Mechanical lift training was done for all CNAs on 12/6/2023. I started some trainings for the CNA's that were here on the day of the Nurses training fair on 4/3/2025. Schedule requested from V2 for 4/3/2025. The Mechanical lift competency training for most of CNA's is past due about 6 months. I have a skills fair I am planning for September for CNA's.</p> <p>Maintenance logs provided to surveyor for six pieces of equipment. V2 stated some may be sit-to-stands and some Mechanical lifts. I do not think they have maintenance logs for the rented Mechanical lift . Surveyor requested to go with V2 to go match up serial numbers from maintenance logs with Mechanical lifts in the building.</p> <p>On 6/17/2025, at 11:49 AM, Surveyor went with V2 to look at all Mechanical lifts and match up serial numbers with Mechanical lifts from maintenance logs. 2 Mechanical lift and 1 sit to stand lift noted on (hall) (3). Medicare area noted to have 2 Mechanical lifts in that area. V2 stated there are 4 Mechanical lifts in the whole building. The other two maintenance logs are for sit to stand lifts. Surveyor asked V2 to provide surveyor with a report showing how many residents need to use the Mechanical lift.</p> <p>On 6/17/2025, at 2:22 PM, Surveyor reviewed list of residents who are care planned to use mechanical lift with 2-person transfer or mechanical lift and there are 18-24 residents in the building who use this type of lift per provided list.</p> <p>On 6/17/2025, at 11:55 AM, V7 Maintenance Director stated we do not do maintenance on rented Mechanical lifts as they are rented. I think we have 3 Mechanical lifts in the building. I do not know how many residents</p> | S9999   |  |   |

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| S9999  | <p>Continued from page 10<br/>use Mechanical lifts in the building.</p> <p>On 6/17/2025, at 12:44 PM, training records provided to surveyor for 18 CNA's showing annual competencies completed on 4/3/2025 including total body lift including V6 CNA and V8 CNA.</p> <p>On 6/18/2025, at 1:00 PM, Administrator provided surveyor a list of current CNA's showing a total of 48 CNA's currently employed.</p> <p>On 6/17/2025, at 1:16 PM, V7 stated, we currently have 4 Mechanical lifts in the building currently all owned by us. We do monthly checks on those lifts unless staff notified us that there is a problem then we check them whenever staff brings to us or tells us about it. V14 Scheduler/Ancillary Clerk lets me know when we have a rental Mechanical lift in the building. I do not do any type of maintenance on those lifts. If anything goes wrong with them, we call the company and they come out and service or replace them right away. The lift that R2 fell from I did not tighten any screws to that lift unless my assistant did that, we are not supposed to do any maintenance on these lifts or equipment. We are not even supposed to touch them lifts. When surveyor told V7 that the staff stated maintenance tightened the screws V7 stated I am going to have to get on V13 Maintenance Assistant about that then. Anything the other companies bring we call them for maintenance on that, we are not supposed to touch them.</p> <p>On 6/17/2025, at 1:30 PM, V13 stated the Mechanical lift that R2 fell out of staff did bring that Mechanical lift down to me to tighten the screws. I did tighten the screws on it. I did tighten the screws on it after the fall. This was a rental Mechanical lift . The screws were loose and it had more play in it than we would like. We normally do not work on the rental equipment that is why I suggested it to be sent back. I did not know if they were going to come with a new rental or not and wanted it to be operational and safe that is why I tightened the screws on that (mechanical lift). As soon as that happened, we took it off the floor. When asked why you tightened the screws if you pulled the lift off of the floor right away V13 stated when I tightened the screws I had not talked to V2 at that point, but my suggestion was to get it replaced. I spoke to V2 and that is when it got taken off the floor. V7 stated I am not sure how long it usually takes to pick up or service equipment that would be V14. The companies do not come out and service their equipment unless we call them. I am not sure if they have a contract to do upkeep on their equipment on a certain schedule. That would be a V14 question. I have</p> | S9999   |  |   |

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| S9999  | <p>Continued from page 11<br/>not seen them come out and just check on equipment that does not have any problems.</p> <p>On 6/17/2025, at 1:40 PM, V14 stated I am in charge of ordering rental equipment and notifying companies when their equipment needs servicing. Usually, it takes about a day or two to come and pick up or service equipment. Unless we have a problem with the equipment, the companies do not come out and maintain the equipment like Mechanical lifts, beds, broda chairs, floor mats, etc. The companies that provided oxygen and CPAP machines do come out about every 2 months and check on their equipment. We are not supposed to do any maintenance on outside company equipment. Surveyor asked is there anything that could have been done to prevent R2's fall from Mechanical lift. V14 stated in my opinion me being a CNA for umpteen years I would have noticed the arm being loose. Maybe a newer CNA would not have noticed that.</p> <p>R1 is a 66-year-old resident initially admitted to facility on 4/25/2023 with diagnoses including but not limited to: transient cerebral ischemic attack, vascular dementia unspecified severity with behavioral disturbance and major depressive disorder.</p> <p>R1's Minimum Data Set (MDS) section C0500 dated 4/30/2025 documents Brief Interview for Mental Status (BIMS) score = 06 which suggests severe cognitive impairment. MDS section GG0130 dated 4/30/2025 documents resident needs set up or clean up assistance with eating. Resident needs substantial/maximal assistance with lower body dressing, putting on/taking off footwear, and personal hygiene. Resident is dependent on staff for oral hygiene, toileting hygiene, shower/bathe self, and upper body dressing.</p> <p>R1's Fall risk assessment dated 4/29/2025 documents resident is a high falls risk with score of 15.</p> <p>R1's Progress note dated 6/6/2025 documents: Note Text: Staff brought resident while in his wheelchair to the nurses cart and stated that the resident almost fell, (V4) CNA (certified nursing assistant) states that resident was standing while holding onto the side rails of the wall and as an attempt was made to sit down in his wheelchair resident missed the wheelchair and V4 CNA assisted resident to the floor with no injuries, no injuries noted. Resident assessed, vitals WNL, denies pain, no further actions required at this time.</p> <p>On 6/16/2025, at 10:55 AM, R1 noted to be sitting in wheelchair in front of nursing station. Surveyor asked staff to see if R1 would talk to surveyor in his room.</p> | S9999   |  |   |

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| S9999  | <p>Continued from page 12</p> <p>R1 agreed to talk to surveyor in his room. R1 noted to be sleepy sitting in wheelchair with eyes opening and closing during wheelchair transfer to room by staff. R1 stated he was ok. R1 stated he did not have a fall recently. Everyone treats me ok. When asked if anyone pulled the wheelchair out from underneath R1 he stated "yes" and stated the first name of V4 when asked who did that. When R1 was asked if he fell when the wheelchair was pulled from underneath R1 he stated "yes". I do not remember what day she (V4) pulled the wheelchair from underneath me. Resident could not answer why V4 pulled the chair from underneath of R1 or if it was an accident or on purpose. R1 clean and well groomed. No foul odors noted.</p> <p>On 6/17/2025, at 10:42 AM, R1 was in dining room alone at a table close to doors by nursing station. R1 stated I did not fall out of my wheelchair recently. Someone pulled the chair out from underneath of me. It was the nurse. R1 stated her name was the first name of V4. When asked how it happened R1 stated I was sitting down. She (V4) was trying to push me out of the dining room. She (V4) was pushing me backwards in the wheelchair. I fell to the ground. She (V4) helped me back up. I did not get hurt. I did not have any pain or bruises.</p> <p>On 6/16/2025, at 11:58 AM, V4 stated I do recall an incident with R1 almost falling out of the wheelchair. I do not recall the exact date. I think it was a Thursday about a week and a half ago. I am pretty sure it was a Thursday. All that happened was that R1 was trying to stand up and was trying to grab on to a door handle and R1 is a high fall risk. So, I went over to R1 and tried to sit him down and he grabbed on to the handrailing and was holding on really tight and so I went to move the chair because the chair was stuck. R1 was standing up at that point, and I went to move the chair and R1 started wobbling and he lowered himself to the floor as I was standing by him. R1 was taken to the nurse (V3) Registered Nurse (RN) and I let her know R1 had an assisted fall to the floor and everything was witnessed. No one else that I am aware of witnessed the fall besides me. I was already guiding R1 to sit down when this happened, so it was an assisted lowered to the floor. R1 landed on one of his knees. There were no visible injuries. R1 was acting normal. No complaints of pain. R1 was taken straight to the nurse. The nurse was V3. R1 is a high fall risk. R1 constantly tries to stand up and we have to assist him or redirect him to sit down. R1 was close to the nurse's station but by the corner. R1 is usually at the nurse's station for higher visibility. But R1 can wander around a little bit, but he does not go too far. We all keep an eye and</p> | S9999   |  |   |

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| S9999  | <p>Continued from page 13</p> <p>watch closely the high fall risk residents. R1 was my resident that day. That is my normal assignment. I have had R1 every day I have worked for like a year and a half, so I know him very well.</p> <p>On 6/16/2025, at 1:32 PM, V2 Director of Nursing (DON) stated my expectation of staff regarding documentation is that staff should document incidents before their shift is over. Obviously patient care comes first. There should not be an incident that is documented the next day. For R1, I got a note under my door that a staff member seen resident on the floor, but no incident was reported. I went and talked to all staff members noted in the area that day. My investigation revealed there was a CNA (V4) that was caring for R1 and was rolling him backwards through the door and he grabbed the door frame, and he slid out of the chair. V4 picked him up and put him back in the chair but did not report. The CNA V4 told the nurse V3, get your resident he almost fell. So now I am interviewing everyone and trying to investigate and see what happened. The CNA V4 did not want to get in trouble and did not report so we opened up the incident the next day because we now knew R1 actually fell. V4 was the CNA, and she was terminated after the investigation. Once I got everyone's statements, I suspended V4 for 3 days pending investigation and then terminated her the following Wednesday. We looked at the camera and it doesn't show the area. You can see everyone going over there but cannot see the incident. That is when I started getting statements from everyone I seen in the camera. So, R1 did have a fall, it was not assisted to the floor. V4 was pulling him backwards and R1 put his arms on both sides of door jambs, and R1 braced himself on the door and fell out of wheelchair. R1 was not standing up, V4 was bringing him out of the dining room. I don't think it was intentional, if V4 would have just reported it we would not have a problem. Surveyor asked to see cameras and to see the termination paperwork. V2 DON provided discipline form recommending termination dated 6/10/2025 signed by V4 CNA. V2 DON stated we brought V4 back from suspension and the same day terminated her.</p> <p>On 6/16/2025, at 2:06 PM, V2 DON stated the camera only records for 24 hours and it cycles so we do not have the footage unless maintenance can pull it up. When I looked at it, it was still in the 24 hours. V2 showed surveyor the live footage of the area and where R1 was, which is out of screen view but just to give you an idea of where he was and where it happened. I will go see if maintenance can pull it up for you.</p> <p>On 6/16/2025, at 2:11 PM, V2 DON and V7 Maintenance</p> | S9999   |  |   |

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| S9999  | <p>Continued from page 14</p> <p>Director. V7 stated the cameras only loop for 24 hours. After 24 hours there is no access that we can get. Surveyor asked what happens if something happens on the weekend and now you do not have access to check the cameras. V2 DON stated I think it is the package they bought for the cloud I have been asking them to upgrade it for that reason.</p> <p>On 6/17/2025, at 12:18 PM, V3 Registered Nurse (RN) stated I was working when R1 had his fall. I did not witness it. It (fall) was on a Thursday. I charted on 6/6/2025. I was notified of an incident that he almost fell, and they brought R1 to me on 6/5/2025. On 6/6/2025 I was notified that R1 did have a fall on 6/5/2025 and told to put in my progress note and open an incident on it.</p> <p>R1's Care plan dated 3/3/2024 documents focus: Resident is at risk for falls and injury related to falls due to history of falls, decreased safety awareness due to altered mental status and Dementia. He also has weakness, decreased mobility, and utilizes psychotropic medications.</p> <p>Goals: The resident will not sustain serious injury through the review date.</p> <p>Interventions: Ask the resident every one to two hours if he needs to use the bathroom.</p> <ul style="list-style-type: none"> <li>o Dycem in place</li> <li>o Ensure the transfer path is clear and\or resident is not grabbing stationary objects during transfer.</li> <li>o Give resident verbal reminders not to ambulate/transfer without assistance.</li> <li>o Keep bed in lowest position with brakes locked.</li> <li>o Keep call light in reach at all times.</li> <li>o Keep personal items and frequently used items within reach.</li> <li>o Keep wheelchair out of reach of resident.</li> <li>o Monitor for proper positioning when in bed</li> <li>o Monitor pt closely when in wheelchair.</li> <li>o Observe frequently</li> <li>o Orient resident when there has been changes in</li> </ul> | S9999   |  |   |

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| S9999  | <p>Continued from page 15 environment.</p> <ul style="list-style-type: none"> <li>o Provide resident an environment free of clutter.</li> <li>o Resident has a Bolster mattress.</li> </ul> <p>Safe lifting and moving of residents Policy Revised August 2008 documents (in part): Policy Statement: In order to protect the safety and well-being of staff and residents, and to promote quality</p> <p>care, this facility uses mechanical lifting devices for the lifting and movement of residents. 2. Staff responsible for direct resident care will be trained in the use of mechanical</p> <p>lifting devices. The manufacturer of purchased equipment shall provide initial staff training on the use of mechanical lifts, as well as on the routine checks and long-term maintenance of equipment. Subsequent training and retraining of staff on the use of mechanical lifting devices shall be conducted by designated team leaders. 3. Staff competency in the use of mechanical lifts shall be assessed at least annually.</p> <p>4. Staffing for all shifts will include sufficient numbers of staff members who have been trained in the use of mechanical lifting devices. 5. Mechanical lifts shall be made readily available and accessible to staff 24 hours a day. 6. Mechanical lift equipment shall undergo routine checks and maintenance by the nursing and maintenance staff, respectively, to ensure that equipment remains in good working order.</p> <p>(B)</p> | S9999   |  |   |