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	IL6004253	A. BUILDING: _____ B. WING _____	05/30/2025

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. This REQUIREMENT was not met as evidenced by: Based on observation, record review, and interview, the facility failed to follow its policy to ensure residents who were seated at the same dining table were served meals at the same time. This failure has the potential to affect all 67 residents residing in the facility. FINDINGS INCLUDE: The (State) Ombudsman Program Resident Rights, dated 11/2018, documents, "Your facility	S9999		

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must treat you with dignity and respect and must care for you in a manner that promotes your quality of life."

The facility's Serving a Meal Policy (Undated) documents: "1. Prepare the room or serving area for mealtime (decrease noise level, provide lighting position comfortably) and make sure hands and face are clean. Ideally all residents at a table will be served at the same time or within close proximity of time when eating in the dining room."

On 5/27/25 at the facility's lunch meal dining, facility staff served lunch meal trays to residents in the dining room. Residents seated together at the same tables were not served their meals at the same time. Noted that usually one resident at a table was eating while the other residents sitting at the same table were not served until later.

On 5/27/25 at 12:25pm, staff provided a lunch meal tray for R1. Three residents (R9, R10, and R11) sitting at the same table as R1 were not served meal trays at this same time; approximately 10 minutes passed before staff started to serve R9, R10 and R11's lunch meals.

On 5/27/25 at 12:35pm, R9 stated that she felt she should have food at the same time as R1. R10 indicated she was not okay with not being served at the same time as R1, and then having to watch R1 eat. R10 stated, "Makes me feel hungry."

On 5/27/25 at 12:40 pm, V10 Certified Nursing Assistant/CNA indicated that whichever way the food trays were placed is the food cart is the order in which the staff pull out the meal trays to serve to the residents.

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S9999	Continued From page 2 On 5/27/25 at 12:45, V5 Dietary Manager stated, "This has been addressed several times; brought up at the staff meeting; Administrator (V1) has talked to the CNAs about serving the same table at the same time." On 5/27/25 at 12:47pm, V1 Administrator stated, "Our policy is to try to serve all residents at the same table at one time." The facility's Long-Term Care Facility Application for Medicare and Medicaid (Centers for Medicare and Medicaid Services/CMS 671) form dated 5/27/25 documents 67 residents reside in the facility. (C) (2 of 2): 300.610a) 300.610c)4)F) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed	S9999		

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and dated minutes of the meeting.

c) The written policies shall include, at a minimum the following provisions:
4) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following:
F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident.

These REQUIREMENTS are not met as evidenced by:

Based on observation, interview, and record review the facility failed to follow their policies to implement fall interventions and keep a resident safe for one (R7) of two residents reviewed for falls in a sample of 11. This failure resulted in R7 being sent out to the hospital multiple times and suffering from pain and swelling, abrasions to forehead and scalp, right first metacarpal (wrist) fracture, and left humerus (shoulder) fracture.

Findings include:

The facility's undated Fall Prevention Program documents "Policy: 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." "High Risk Protocols: c. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological,

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cognitive status, or recent change in functional status." "8. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness."

The facility's undated Comprehensive Care Plans policy documents "Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality." "Policy Explanation and Compliance Guidelines: 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being."

The facility's undated Residents Rights policy documents "8. Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely."

1. R7's Progress note, dated 3-19-25 at 6:59pm, documents R7 was found lying on ground face down in front of his wheelchair with a small abrasion found on his forehead. 911 notified for R7 to be sent out to the hospital.

The facility's Unwitnessed Fall Investigation report, dated 3-19-25, documents the following: R7 was seen laying on the ground face first with

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his wheelchair behind him. Abrasion to top of scalp and small abrasion to forehead. The IDT (Interdisciplinary Team) review on 3-20-25 states R7 is to be at the nurses' station for supervision or activity room with activity staff for supervision until he can be laid down in bed. X-rays noted a proximal first metacarpal displaced fracture. V21 Nurse Practitioner/NP contacted for x-ray of left arm/elbow. R7's Care plan includes but is not limited to "(R7) is at risk for falls related to Confusion, Gait/balance problems, Unaware of safety needs and non-ambulatory." Interventions include but are not limited to "Resident to be laid down after meals, dated 11/17/2024 by V3 Assistant Director of Nursing/ADON."

R7's current Physician Order Sheet/POS documents R7 has diagnoses including but not limited to Alzheimer's Disease with early onset; Down Syndrome; Severe Intellectual Disabilities; and Unspecified Dementia, Unspecified Severity, with other Behavioral Disturbance; and Impulse Disorder.

R7's Fall Risk Evaluation, dated 2/9/25, documents R7 as a high fall risk.

R7's Minimum Data Set/MDS assessment, dated 5/13/25, documents R7 is severely cognitively impaired and dependent on staff for Activities of Daily Living/ADLs including transfers.

R7's current Care plan includes R7 is at risk for falls related to confusion, gait/balance problems, unaware of safety needs and non-ambulatory. Interventions include but are not limited to "Resident to be laid down after meals," dated as initiated on 11/17/24.

R7's Progress note, dated 3-19-25 at 11:34pm,

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"Resident was brought back to facility after being sent out due to an un-witnessed fall. When assessing resident post fall, resident has two reddened areas to the forehead. In the middle of forehead measures 3.5cm (centimeters) L (long) x 1cm W (wide). On the top of forehead measures 1cm x 0.5cm."

R7's Progress note, dated 3-20-25 at 10:34am, documents, "ER (Emergency Room) called and stated resident needs to come back that they reviewed his X-ray again and say a fracture in his right wrist. Family notified, Ambulance called, and ER notified that he also needs an X-ray of Left Elbow/Arm for discomfort."

R7's Progress note, dated 3-20-25 at 2:37pm, documents, "Resident returned from Hospital with Diagnosis of Open Displaced Fracture of base of first Metacarpal bone of right hand unspecified Fracture Morphology." "Resident is in a right arm post mold with splint. It should not be taken off, it cannot get wet, circulation should be checked, and skin should be checked for rubbing. Per ER (Emergency Room) X-ray done on left arm and hand but has not yet been resulted."

R7's Progress note, dated 3-21-25 at 10:20am documents, "Noted resident to have mild edema to left shoulder. CNAs (Certified Nursing Assistants) noted resident guarding area. Called POA (Power of Attorney) regarding update of condition to LUE (left upper extremity). He states he would like resident to have X-ray of LUE. NP (V21 Nurse Practitioner) notified and new order received for X-ray of LUE/Shoulder and to schedule Tylenol 650mg (milligrams) Q6 (every six hours). POA is aware."

R7's Progress note, dated 3-22-25 at 4:33pm,

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documents, "(Named) Radiology arrived at 4:20pm to XR (X-ray) resident's humerus/left shoulder. After XR was completed tech (technician) noted that there was possible break & asked if order can be noted as STAT (immediately) that way it will be read tonight. Resident did well for XR but c/o (complained of) pain with every movement of that Lt (left) arm/shoulder. Resident given pain medication at this time."

R7's Progress note, dated 3-22-25 at 6:25pm, documents Left humerus/Left shoulder X-rays results of "Acute mild impacted nondisplaced humeral neck fracture."

R7's Progress note, dated 3-22-25 at 6:32pm, documents (V25 previous Medical Director) responded with orders to immobilize, sling extremity, and no weight bearing. Reply to V25 was that facility does not have equipment at the facility to do this, so it is recommended that R7 return to the ED/Emergency Department.

R7's Progress note, dated 3-22-25 at 7:19pm, documents R7 was being transferred by ambulance back out to the ED for evaluation of left humeral neck fracture.

R7's Progress note, dated 3-23-25 at 12:04am, documents R7 returned to the facility, received Tylenol with Codeine for pain in the ED, and had a sling in place to his left upper extremity.

R7's Physician progress note, dated 3-25-25 at 5:31pm, documents the following: R7 has a right first metacarpal base fracture and left proximal humerus fracture; right hand and left shoulder pain is controlled at rest. New/revised orders include No Weight Bearing/NWB right hand,

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thumb splice brace left hand, NWB Left Upper Extremity/LUE, sling left arm for six weeks, pain control, ice and elevate hand for swelling.

R7's Radiology Report of R7's right hand, dated 3/20/25, documents, "Impression: Proximal first metacarpal displaced fracture, possibly intra-articular/comminuted, consistent with unstable fracture."

R7's Radiology Report of R7's left shoulder, dated 3/22/25, documents, "Conclusion: Acute mild impacted nondisplaced humeral neck fracture."

On 5/29/25, at 1:36pm, V22 Agency Registered Nurse/RN stated V22 was not familiar with R7 and was unaware if he was a fall risk. V22 confirmed R7 is not aware of his own safety needs. V22 stated, "I was unsure if it was okay to leave him in the hall. I thought well he doesn't move so I guess it is okay." "(R7) should have been left in the dining hall or a place where more than one eye can be on him." V22 stated she was unaware of (R7's) care plan or if (R7) was to be laid down after meals.

On 5/29/25, at 2:21pm, V23 Certified Nursing Assistant/CNA stated the following: V23 and V24 CNA were working on R7's hall. V23 stated V22 Agency Registered Nurse placed (R7) in the hallway. "He was in a (reclining wheelchair). (R7) is supposed to be laid down after meals. (R7) should have gone straight to his room to be laid down."

On 5/29/25, at 2:41pm, V3 Assistant Director of Nursing/DON stated regarding R7's fall on 3-19-25, the root cause was "(R7) was outside of his room waiting to be put down." V3 confirmed

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R7's current Care plan states R7 is to be laid down after meals and that this fall occurred following R7 leaving the dining room from the evening meal.

On 5/30/25, at 10:49am, V21 Nurse Practitioner/NP stated, "If they did not follow (R7's) risk reduction plan then there was an increased risk of (R7) falling."

2. On 5/28/25, at 12:50pm, R7 sat in a reclining wheelchair across from his room in the hallway approximately three quarters down the hall from the nurses' station in a reclined position. With continuous observation, R7 sat in this location until 1:49pm when V17 and V18 Certified Nursing Assistants/CNAs wheeled him into his room to lay him down in bed. Using the mechanical lift, they put R7 to bed. They placed a pillow under R7's right side and a wedge under his left side.

On 5/28/25, at 1:49pm, V17 Certified Nursing Assistant/CNA stated that the wedge pillow goes under this side (pointing to his left side) because when he falls out of bed it is usually on this side. V17 stated some residents are to be the last to get up and the first to lay down, but not on this hall (where R7 resides). V17 and V18 CNAs verified R7 has fallen out of his reclining wheelchair and his bed before.

On 5/28/25, at 3:40pm, V4 Assistant Director of Nursing/ADON stated a wedge cushion should be placed under R7's right side since that is the side of bed he was rolling out of. V4 stated R7 should not have been left in the hallway. R7 is to be in a high visual area before being laid down after meals.

R7's Care plan includes R7 is at risk for falls with

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interventions including but not limited to positioning a wedge to his right side when in bed, dated 4/6/2025; resident to be at nurses' station for supervision or activity room with activity staff for supervision until he can be laid down in bed, dated 3/20/2025.

3. On 5/29/25, at 10:00am, R7 was lying in bed with a wedge pillow on his left side and a pillow to his right side.

On 5/29/25, at 10:05am, V15 Certified Nursing Assistant/CNA stated, "(V16/CNA) and I put (R7) to bed. We put the wedge on his left side because he likes to crawl out of bed. It is a fall intervention. We put it on his left side since that is the side he fell on. The pillow goes on his right."

On 5/29/25, at 10:07am, V16 CNA stated that V16 puts the wedge on the side his body is going /leaning towards or the direction his feet are crossed towards when they lay R7 down.

On 5/29/25, at 10:17am, V15 CNA stated that they just looked at the report sheet and saw that the wedge is to be on R7's left side. V15 said, "We were wrong."

The facility's undated staff report sheet documents R7 is to have a wedge on his right side, pillow on his left side, and is first down and last up for meals. (B)