STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145439	A. Building B. Wing	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accolade Healthcare of Savoy	302 West Burwash Savoy, IL 61874

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 35046 Based on observation, interview, and record review the facility failed to prevent the verbal and physical abuse of one (R1) of three residents reviewed for abuse on the sample list of eight. This failure resulted R1 having mental anguish during the abuse and continued mental anguish following the abuse. Findings include: The facility's Final Investigation Incident Report dated 11/19/21 documents on 11/16/21 at 5:50 AM, the facility received an allegation of physical and verbal abuse of R1 by a Certified Nursing Assistant (V5). This report documents R1 as alert and oriented. This report also documents that, (V5) will be separated from the company for unprofessional behavior. During interviews on 11/29/21 at 11:57 AM and 12/6/21 at 10:53 AM, R1 stated she had a problem with V5 Certified Nursing Assistant (CNA) a couple weeks ago (11/15/21). R1 stated she needed to get ready for therapy after lunch, so she put on her call light and V5 responded. R1 stated that V5 told her she would be right back. R1 stated she kept seeing V5 walk by her room and was talking to other people. R1 stated she saw V5 walk by again, so she hollered out that she needed to get ready. R1 stated. she came in and got face to face with me and screamed that she was not going to be yelled at and that she had been cleaning up (expletive for feces) all day. R1 put her hand about four inches from her face and stated with tears in her eyes that, she was this close and screaming curse words at me including (f-word) and was saying you aren't going to tell me what to do. R1 stated, I asked her to calm down and even told her that she was my favorite because she was losing it and wouldn't quit yelling. I was trying to smooth her over. Then, she grabbed my arm and yanked me over and it hurt my arm. I was scared of her. I was scared she was going to hit me. R1 stated V5 came in one more time that day and I was crying and then V5 asked why, and I told her she forgot to change my pad and gown. R1 stated V5 changed it without incident. R1 stated V6 CNA came on duty that evening and that the next morning V6 seen her crying. R1 stated V6 asked what was wrong so I reported the incident to V6. R1 stated R1 didn't see V5 after that. R1 stated during the incident she was very scared of V5. R1 stated tearfully that, I think about it every day and I am so worried that she might do this to someone else. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R1's Witness statement dated 11/16/21 at 7:58 AM documents, About 12:15 PM I had my light on and (V5) came in and I asked her to change me, and she said she was about to feed (another resident) and she would change me after. A time passed and I seen her coming out of (another resident's room) and said (V5), I need to be changed, (they) want me to do therapy. She got really close in my face and was yelling at me. I've got all these people to take care of. I clean (expletive for feces) and I get no respect. She snatched my covers down and threw them to the floor and I said please don't yell at me. She snatched my arm to turn me over and I said wait (V5) my arm. She said I've been on this hall and they (2 other residents) are my witness that you are yelling at me to change you. She changed me and didn't change my bed pad or gown. She said you will probably call your (family member) and (V1, Administrator) but V1's in the hospital. I told her, I am going to report her, and she said if you don't then the b****h across the hall would. She (V5) gets mad sometimes, but she was bad this time and I was scared. On 11/29/21 at 12:34 PM, V6 stated around 5:00 AM on 11/16/21 R1 told me that she asked V5 to change her and that she left the room to help another resident. V6 stated R1 said 45 minutes had passed so she yelled at V5 to come in and change her. V6 stated R1 said V5 was screaming in her face not to be telling her what to do. V6 stated R1 said she was yelling and yanking her arm and her arm hurt. V6 stated R1 is reliable, she was upset and was crying. I reported it immediately. V6's Witness Statement dated 11/16/21 at 7:28 AM documents, I went in to check on (R1) and she asked if she could talk to me and if I would not say anything. I told her yes and she started crying. She said she asked (V5) to change her and (V5) said she would change her after she fed (another resident). V5 left. Therapy said they would work with her after she was cleaned up. About 45 minutes later she heard (V5) in the hall and called for her. V5 came in the room yelling and told her, I will change you when I get to you, don't tell me what to do. She (V5) was roughly grabbing her arm. (R1) said (V5) you're hurting my shoulder. (V5) snatched her blanket off of her and threw it. (V5) changed her but left her on a wet bed pad. (V5) said what are you going to do, call your (family member) and report me? V5's Witness Statement dated 11/16/21 at 7:30 AM documents, (R1) asked during the lunch meal to be changed. I stated I would change her after feeding (another resident) and picking up trays. (R1) said okay. I leave (another resident's room) and two lights are on. I answered (another resident's) light first. As I am in (that) room (R1) yells from her room, I need changed, you said you would, and therapy needs me. So, I leave (that) room and go to (R1's) room and said, Do not yell at me please, I said I would change you after (caring for the other resident) and I did not forget, and therapy did not tell me that you needed to get up so don't yell. (R1) started crying and I changed her. Twenty minutes later, I go back because (R1) had her light on. She states you changed me too quick, and my pad and gown are wet. I said okay I'm sorry and changed them. On 12/2/21 at 10:52 AM, V2 Director of Nursing stated when she interviewed R1, R1 was pretty upset. V2 stated R1 was scared, V2 stated R1 is high-strung but she was more upset than usual. V2 stated during the interviews R1 stated V5 yelled at her and V5 claimed she didn't. V2 stated she felt like their stories were similar enough. V2 stated, I didn't like that (R1) felt afraid so I told (V5) she could resign, or I would terminate her position, either way I didn't feel comfortable with her (V5) working in the facility. V2 stated R1 is alert and oriented and R1's account of the incident hasn't changed.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 35046 Based on interview and record review the facility failed to follow its abuse prevention program by failing to prevent the verbal and physical abuse of one (R1) of three residents reviewed for abuse on the sample list of eight. Findings include: The facility's Abuse Prevention Program dated November 2017 documents, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, or mistreatment of residents. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, or mistreatment of residents. This program defines the term Verbal Abuse as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families. This program provides examples of Verbal Abuse as threats of harm and saying things to frighten a resident. This program defines Physical Abuse as the infliction of injury on a resident that occurs other than by accidental means. The facility's Final Investigation Incident Report dated 11/19/21 documents on 11/16/21 at 5:50 AM, the facility received an allegation of physical and verbal abuse of R1 by a Certified Nursing Assistant (V5). This report documents R1 as alert and oriented. This report also documents that, (V5) will be separated from the company for unprofessional behavior. During interviews on 11/29/21 at 11:57 AM and 12/6/21 at 10:53 AM, R1 stated V5 yelled profanities at her and pulled her arm forcefully while turning her and hurt her arm. R1 stated she was scared and was afraid V5 would hit her. R1 stated the incident scared her. On 12/2/21 at 10:52 AM, V2 Director of Nursing stated when she interviewed R1 regarding the incident with V5. V2 stated R1 was pretty upset and was scared. V2 stated, I didn't like that (R1) felt afraid so I told (V5) she could resign, or I would terminate her position, either way I didn't feel comfortable with her (V5) working in the facility. V2 stated R1 is alert and oriented and R1's account of the incident hasn't changed.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to notify a physician of a resident's change in level of consciousness timely following an unwitnessed fall for a resident on an Anticoagulant (blood thinner), resulting in a delay in treatment for one of three residents (R7) reviewed for falls in the sample list of eight residents. This failure resulted in prolonged bleeding and a delay in R7 being hospitalized and treated for an acute intraventricular hemorrhage (brain bleed). Findings include: R7's Diagnosis List dated 12/2/21 documents R7 has diagnosis of Atrial Fibrillation with long term use of Anticoagulants, and Dementia. R7's Care Plan revised on 10/5/21 documents R7 receives an anticoagulant and includes interventions to monitor, document, and report as needed adverse reactions of anticoagulant use including lethargy and changes in mental status, review medications list for adverse interactions, and avoid use of aspirin or NSAIDS (Nonsteroidal Anti-inflammatory Drugs). R7's Order Summary Report dated 11/15/21 documents R7's orders include Eliquis (anticoagulant) 5 mg (milligrams) twice daily, and Meloxicam (NSAID) 7.5 mg daily. R7's November 2021 Medication Administration Record documents R7 received Eliquis, and Meloxicam as ordered from 11/1-11/15/21. R7's Neurological Assessment Flow sheet for R7's fall on 11/8/21 documents post fall Neurological assessments are scheduled every 15 minutes x4, then every 30 minutes x2, then hourly x4, then every 4 hours x4, then every 8 hours x6. This form documents to assess vitals, pupil reaction, level of consciousness, hand grasps, and movement. V19 Licensed Practical Nurse (LPN) Witness Statement documents: R7 fell on [DATE] in the bathroom. V19 did not see R7 until R7 was brought to the nurse's station following the fall. V19 described R7 as having a flat affect and kind of lethargic. R7's right Sclera was red/bloody and R7's right cheek was bruised. R7's Progress Notes document: On 11/11/21 at 4:10 PM R7 had a witnessed fall in the hallway and sustained a 1.5 cm (centimeter) laceration to the right eyebrow. On 11/12/21 at 12:58 PM R7 was asleep, stayed in bed all morning, had 3 cups of water but no food intake for breakfast. On 11/13/21 at 1:02 PM R7 was asleep in bed most of the shift. Prior to 11/12/21 R7 is documented as ambulatory, wandering the unit, and self-transferring at times. On 11/13/21 at 7:00 PM R7 was found on the floor in R7's bathroom, and redness was noted to R7's Sclera. An initial Neurological assessment was completed. V18 Physician and R7's family were notified. R7's medical record only documents Neurological assessments were completed at the time of R7's fall and on 11/14/21 at 5:27 AM. On 11/14/21 at 6:06 PM V18 and R7's family were notified of periorbital redness. On 11/15/21 at 2:51 PM V15 Nurse Practitioner assessed R7 and gave orders to send R7 to the emergency room due to the fall, increased bleeding to the right eye, and R7 receiving Meloxicam and Eliquis. There is no documentation in R7's medical record that R7 had increased lethargy following the fall on 11/13/21, and that R7's lethargy was reported to V18. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R7's emergency room (ER) notes dated 11/15/21 at 3:14 PM document: R7 had fallen in R7's bathroom yesterday, and today bruising was noted to R7's right eye. Clinical Impression: Intracranial bleed. R7's Computed Tomography (CT) of the head or brain dated 11/15/21 at 4:33 PM documents: Acute intraventricular hemorrhage without hydrocephalus. Non-hemorrhagic 0.5 cm (centimeter) right frontal subdural hygroma (collection of spinal fluid). Findings are new since the previous head CT (on 4/7/21) and most likely represents posttraumatic hemorrhage. R7 was transferred to another hospital. R7's Neurosurgery Consult Notes dated 11/15/21-11/17/21 document: R7 was given Kcentra (medication used to reverse anticoagulation) at prior hospital after CT showed right lateral ventricular hemorrhage and blood pooling in the left lateral ventricle. R7's CT Angiography ruled out a vascular source of the brain bleed. On 12/1/21 at 11:00 AM V7 Registered Nurse (RN) stated: V7 was working when R7 fell on [DATE]. It was in the evening, and R7 was walking in the hall. Staff witnessed R7 walking and fall forward to the floor. R7 sustained a right eyebrow laceration. R7 fell again a few days later. Prior to the falls R7's gait was unsteady, R7 needed assistance of 1 staff person and other times R7 would walk by R7's self. On 12/1/12 at 1:07 PM V7 stated V7 worked dayshift on 11/14/21 and R7 did not get out of bed at all that shift. V7 stated I wouldn't say (R7) was (R7's) normal self that day. R7 took more time to respond, and V7 did not complete a Neurological assessment that shift. V7 did not notify anyone that day in regard to R7. On 12/1/21 at 11:56 AM V11 CNA stated: Before R7 fell , R7 would stumble while walking and staff would have to sit R7 down. R7 was able to ambulate independently. After R7's fall on 11/13/21, R7 stayed in bed more and R7 was not alert. It was difficult to wake R7 up at times. Sometimes R7 would wake up and feed R7's self. R7 stayed in bed all day on first shift on 11/14/21 and 11/15/21, and R7 was not up walking around like R7's usual self. That was new for R7. On 12/1/21 at 2:50 PM V10 CNA stated: The last few falls really did (R7) in. After that last fall (R7) wasn't (R7's self). R7 wasn't getting up out of bed as much. R7 was in the bed and not responding to V10 on the evenings of 11/13/21 and 11/14/21. We thought R7 hit R7's head hard and thought R7 had a brain bleed. V10 told the nurse (V9) that, and V2 Director of Nursing as well. I (V10) don't know why they didn't send (R7) out to the hospital sooner. By Sunday (11/14/21) R7's cheek bruise was larger and (R7's) right eye was blood shot. On 12/1/21 at 1:29 PM V9 RN stated: On 11/13/21 at approximately 7:00 PM, V9 found R7 lying on the floor of R7's bathroom. R7 had discoloration to R7's right cheek and right eye Sclera redness. V9 completed an initial Neurological assessment. V18 Physician and R7's family were notified of the fall and Sclera redness. The following day on 2nd shift, V9 noticed the redness to the Sclera had increased and spread to the periorbital area. V9 notified V18 Physician and R7's family. On 11/14/21 R7 was in bed for the entire 2nd shift. R7 did sit up on the side of the bed and fed R7's self-supper. On 11/15/21 V9 asked V15 Nurse Practitioner to assess R7. V15 gave orders to send R7 to the emergency room and R7 was admitted to the hospital. V9 forgot to complete the paper form for R7's post fall Neurological assessments. V9 confirmed V9 did not complete post fall Neurological assessments following R7's initial assessment after the fall on 11/13/21. On 12/2/21 at 10:24 AM V9 stated: V9 reported R7's fall and sent a picture of R7's reddened Sclera to V18 via text message on 11/13/21 around 7:00 PM. V18 returned a text message at 8:00 PM that said subconjunctival hemorrhage and no new orders. On the evening of 11/14/21 V9 sent another text message to V18 that said R8's Sclera redness had increased, and V18 replied ok. V9 did not mention R7's anticoagulant use to V18. V9 did not report R7's lethargy on 11/14/21 to V18, since R7 sat up and ate supper. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 12/2/21 at 1:15 PM V19 RN stated: V19 saw R7 shortly after R7's fall on 11/13/21. R7 usually wanders and is unsteady. That night R7 was sitting in a chair or wheelchair in the common area. R7's head was down and R7 wasn't really responsive and acting weird. V19 questioned what had happened and was told R7 fell . V19 noticed R7's Sclera was red. R7 would respond to R7's name by looking up, and then back down. V19 told V9 that V19 thought R7 may need to go to the hospital. V19 did not notify anyone since V19 was not R7's assigned nurse. On 12/1/21: At 1:13 PM V2 Director of Nursing stated: Neurological assessments are to be completed for unwitnessed falls or if the resident hits their head. Initial Neurological assessments are documented in the fall note, and then after that the assessments are documented on the paper Neurological flow sheet. V2 stated V2 did not have any Neurological assessments to provide following R7's fall on 11/13/21. The nurses told V2 the assessments weren't done. At 2:26 PM V2 stated: Prior to R7's fall on 11/13/21 R7 would ambulate independently about the unit. V2 would consider R7 spending an entire 1st or 2nd shift in bed a change in condition for R7 and expect to be reported to V18 and V2. V2 was not aware that R7 was lethargic and not getting out of bed prior to R7's hospitalization . V2 was not sure what the facility's policy was regarding unwitnessed falls for residents who are on anticoagulants, that was in place at the time of R7's fall. After R7's fall, the facility implemented a new policy that residents will be transferred out for evaluation if an unwitnessed fall or head injury occurs, and the resident is on anticoagulants. Attempts were made to contact V18 Physician but were unsuccessful. On 12/1/21 at 1:52 PM V15 Nurse Practitioner stated: R7 has had several falls. On 11/15/21 V9 reported R7's November falls to V15 and requested V15 assess R7. V9 told V15 that R7 had not been acting right since R7's fall on 11/13/21. V15 noted a change in R7's condition. R7 had bleeding/redness to R7's right eye and bruising to R7's right cheek. The bleeding of R7's eye was very concerning since R7 is on Eliquis and had fallen. R7 was admitted to the hospital with an intraventricular hemorrhage. If a resident is on anticoagulants and has an unwitnessed fall V15 likes to see them sent to the emergency room for evaluation, but V15 was not sure if that is the facility's policy. V15 would expect the nurses to complete post fall Neurological assessments for residents who had an unwitnessed fall and take an anticoagulant. On 12/2/21 at 11:17 AM V15 was asked what could happen as a result of prolonged bleeding and a delay in sending R7 to the emergency room . V15 stated: There could be permanent Neurological deficits similar to a stroke such as altered mental status, poor strength, and could absolutely lead to death if left untreated. The facility's undated Anticoagulation Therapy policy documents: The Nurse on Duty and/or Attending Physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. a. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria (blood in urine), hemoptysis (blood from the respiratory tract) or other evidence of bleeding, the Nurse on Duty will discuss the situation with the Attending Physician before giving the next scheduled dose of anticoagulant. The facility's Change in a Resident's Condition or Status policy revised November 2021 documents: The physician/practitioner will be notified of changes in the resident's mental/medical condition including a need to alter the resident's medical treatment, transfer the resident to the hospital, and changes in the resident's physical/emotional/mental condition. If the change in condition is emergent, contact 911 and transfer the resident to the hospital. Record assessment and observation information in the resident's medical record regarding changes in the resident's condition.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to accurately complete fall risk assessments, complete post fall neurological assessments, implement post fall interventions and therapy recommendations, and thoroughly complete post fall investigations for two of three residents (R7, R8) reviewed for falls in the sample list of eight residents. This failure resulted in R7 falling and sustaining an acute intracranial hemorrhage (brain bleed) following an unwitnessed fall. Findings include: 1. R7's Diagnosis List dated 12/2/21 documents R7's diagnosis include Atrial Fibrillation with long term use of Anticoagulants (blood thinner), and Dementia. R7s Minimum Data Set (MDS) dated [DATE] documents R7 has short term and long-term memory impairment and is moderately impaired with decisions. R7 uses limited assistance of one staff person for transfers and walking in the room and corridor. R7 is not steady during transitions and walking and requires staff assistance to stabilize balance. R7 uses extensive assistance of one staff person for toileting and is frequently incontinent of bowel and bladder. R7's Care Plan revised on 10/5/21 documents R7 is at risk for falls and includes interventions to ensure that R7 is wearing appropriate footwear when ambulating or mobilizing in wheelchair, and R7 needs a safe environment including even floors free from spills and/or clutter. R7's Care Plan revised on 10/25/21 documents R7 had a fall and includes an intervention dated 10/25/21 to assist with lying down for rest periods as tolerated when noted to be tired, and an intervention dated 11/8/21 to encourage resident to wear nonskid socks instead of shoes when ambulating. R7's Order Summary Report dated 11/15/21 documents the following orders: Trazodone (Psychotropic) Hydrochloride take 100 mg (milligrams) daily. Depakote (Antiseizure) take 250 mg twice daily and 500 mg daily at bedtime. Eliquis (Anticoagulant) take 5 mg twice daily. Meloxicam (NSAID) take 7.5 mg daily. Metoprolol Tartrate (Antihypertensive) take 25 mg twice daily. Risperdal (Psychotropic) take 0.5 mg twice daily. Zoloft (Psychotropic) take 25 mg daily. R7's Physical Therapist Progress & Discharge Summary, recorded by V17 Physical Therapist, dated 10/15/21 documents: R7 is able to maintain standing balance without handheld support, may require occasional contact guard assist for less than 10 minutes. R7 requires supervision in gait due to impaired safety awareness. R7 will need a supervised walking restorative program set up to allow R7 to rest in order to prevent falls due to fatigue from overuse of prolonged weight bearing. Staff was provided education on the ambulation program. There is no documentation in R7's medical record that R7's supervised walking restorative program was implemented as recommended by V17. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R7's Progress Notes document: On 10/23/21 at 9:15 PM R7 was wandering the hallways and was wobbly at times. R7 needed frequent reminders to sit in a chair or wheelchair. On 10/24/21 at 11:04 PM R7 had an unwitnessed fall. R7 was found in another resident room, lying on R7's back. R7 had a skin tear to the right elbow and R7's pupils were equally reactive to light. The only post fall Neurological assessment documented following this fall is on 10/25/21 at 3:35 PM. On 11/8/21 at 6:15 PM R7 was walking at a fast pace, leaned forward, lost balance and fell forward to the floor causing R7 to hit R7's forehead. R7 had a small, reddened area to R7's forehead and an initial Neurological assessment was completed. R7's nursing notes document Neurological assessments were not completed again until 9:53 PM on 11/9/21 and then not again until 11/10/21 at 4:10 PM. On 11/11/21 at 4:10 PM R7 had a witnessed fall in the hallway and sustained a 1.5 cm (centimeter) laceration to the right eyebrow. A Neurological assessment was completed at the time of R7's fall and on 11/12/21 at 5:18 AM. There are no other Neurological assessments documented following R7's fall on 11/11/21. On 11/13/21 at 7:00 PM R7 was found on the floor in R7's bathroom, and redness was noted to R7's sclera. An initial Neurological assessment was completed. R7's medical record only documents Neurological assessments were completed on 11/14/21 at 5:27 AM after this fall. R7's Neurological Flow Sheet for R7's 11/8/21 fall does not document Neurological assessments were completed as scheduled at 9:00 PM and 10:00 PM on 11/8/21, or after 6:00 AM on 11/9/21. This flow sheet documents post fall Neurological assessments are scheduled every 15 minutes x4, then every 30 minutes x2, then hourly x4, then every 4 hours x4, then every 8 hours x6. This form documents to assess vitals, pupil reaction, level of consciousness, hand grasps, and movement. R7's Fall Risk Evaluation dated 10/24/21 documents: A score of 10 or greater indicates the resident is at high risk for falls and prevention protocol should be initiated and documented on the care plan. For the medications section respond on the types of medications used including Antiseizure, Antihypertensive, and Psychotropic medications. R7's Fall Risk score is 8, indicating R7 is not at high risk for falls. This evaluation is not accurate and documents R7 takes 1-2 of the listed types of medications, R7's gait/balance is normal, and R7 is ambulatory and continent of bowel and bladder. R7's Fall Risk Evaluation dated 11/8/21 documents: R7's Fall Risk score is 7. This evaluation is not accurate and documents R7 is ambulatory/continent, and R7 takes 1-2 of the listed types of medications. R7's 10/24/21 fall investigation does not document interviews were conducted with staff. There is no documentation in R7's medical record or fall investigation of when R7 was last observed, or the last time R7 was assisted with toileting or to rest. R7's 11/8/21 fall investigation documents the root cause of R7's fall is believed to be that the rubber soles on (R7's) shoes may have caused (R7) to trip. R7's post fall intervention is to encourage R7 to wear non-skid socks instead of shoes when ambulating. R7's 11/11/21 fall investigation documents the root cause of R7's fall is believed to be that R7 fell due to fatigue. This investigation does not document when staff last assisted R7 to rest prior to the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Final Investigation Report dated 11/22/21 documents: On 11/13/21 R7 was found on the floor in R7's restroom. R7 was barefoot and water was on the floor. R7 had redness noted to R7's Sclera (white part of the eye). During post fall assessments R7 was noted to have increased bleeding to the right eye, was assessed by the Nurse Practitioner (V15), and transferred to the local emergency room . R7's Computed Tomography (CT) scan of the head/brain showed acute Intraventricular Hemorrhage (brain bleed) and Non-Hemorrhagic 0.5 cm (centimeter) right Frontal Subdural Hygroma (collection of Cerebrospinal fluid.) The root cause of R7's fall was believed to be that R7 slipped in water on the bathroom floor. This investigation documents witness statements from V9 RN (Registered Nurse) and V19 LPN (Licensed Practical Nurse.) V9's statement documents: R7 fell on [DATE] in the bathroom. R7 was barefoot, R7's sink was leaking, and the floor was wet. R7 was last seen on the bed. V19's statement documents: V19 did not see R7 until R7 was brought to the nurse's station following the fall. V19 described R7 as having a flat affect and kind of lethargic. R7's right sclera was red/bloody and R7's right cheek was bruised. There are no other documented staff witness statements or interviews. There is no documentation of the time that R7 was last observed prior to the fall, when R7 was last toileted, and if R7 was wearing nonskid socks prior to R7's fall. R7's emergency room (ER) notes dated 11/15/21 at 3:14 PM document: R7 had fallen in R7's bathroom yesterday, and today bruising was noted to R7's right eye. Clinical Impression Intracranial bleed. R7's CT of head or brain dated 11/15/21 at 4:33 PM documents: Acute intraventricular hemorrhage without hydrocephalus. Non-Hemorrhagic 0.5 cm right frontal subdural hygroma. Findings are new since the previous head CT (on 4/7/21) and most likely represent posttraumatic hemorrhage. R7 was transferred to another hospital. R7's Neurosurgery Consult Notes dated 11/15-11/17/21 document: R7 was given Kcentra (medication used to reverse Anticoagulation) at prior hospital after CT showed Right Lateral Ventricular Hemorrhage and blood pooling in the Left Lateral Ventricle. On 11/17/21 R7's CT Angiography ruled out a Vascular source of the Brain bleed. On 12/1/21 at 11:00 AM V7 RN stated: V7 was working during one of R7's falls. It was in the evening, and R7 was walking in the halls. Staff witnessed R7 walking and fall forward to the floor. R7 sustained a right eyebrow laceration. Neurological assessments are done every 15 minutes following a fall and are documented in a progress note or on the Neurological flow sheet. V7 was unsure how long post fall Neurological assessments are to be completed following a fall. R7 fell again a few days later, and V7 was unsure what fall intervention was put into place after R7's fall on 11/11/21. Prior to the falls R7's gait was unsteady and needed assistance of 1 staff person, and other times R7 would walk by R7's self. On 12/1/21 at 11:23 AM V12 Certified Nursing Assistant (CNA) stated: When R7 first came to the facility, R7 ambulated independently. R7 had a fall and then staff started to supervise R7 with walking and used a gait belt if R7 was unsteady. R7 was incontinent and required staff to provide toileting/incontinence care every 2 hours. R7 would self-transfer out of bed at times. V12 was not sure what fall prevention interventions were used for R7. On 12/1/21 at 11:56 AM V11 CNA stated: Before R7 fell , R7 would stumble while walking and staff would have to sit R7 down. R7 was able to ambulate independently. R7's fall interventions included wearing shoes or nonskid socks and direct R7 to sit in the chair or wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/1/21 at 1:29 PM V9 RN stated: On 11/13/21 at 7:00 PM, V9 found R7 lying on the floor of R7's bathroom. R7 was not wearing any clothing and was barefoot. The bathroom floor was wet, and the sink was leaking. R7 had discoloration to R7's right cheek and right eye sclera redness. V9 completed an initial Neurological assessment. The following day on 2nd shift on 11/14/21 V9 noticed the redness to the Sclera had increased and spread to the Periorbital area. V9 notified V18 Physician. On 11/15/21 V9 asked the V15 Nurse Practitioner to assess R7. V15 gave orders to send R7 to the emergency room and R7 was admitted to the hospital. V9 forgot to complete the paper form for R7's post fall Neurological assessments. V9 confirmed V9 did not complete post fall Neurological assessments after the initial assessment for the fall on 11/13/21. On 12/2/21 at 10:24 AM V9 stated: On 11/13/21 V9 saw R7 around the evening medication pass at an unknown time before R7's fall. R7 was lying in bed at that time, and V9 was unsure if V9 had on nonskid socks prior to R7's fall. Shoes or nonskid socks would have helped with traction and may have prevented R7's fall. On 12/1/21 at 2:50 PM V10 CNA stated: V10 worked 2nd shift on 11/13/21 and was assigned to R7's hallway. V10 was unable to recall details of R7 prior to R7's fall and was unsure of the last time R7 had been checked on or toileted prior to R7's fall. R7 is kind of wobbly in the evening after dinner and V10 would typically lie R7 down at that time. V10 stated V10 did not assist R7 into bed prior to R7's fall. R7 would locate R7's room and self-transfer into bed at times. On 12/2/21 at 1:15 PM V19 RN stated: V19 did not see R7 in R7's room at the time of the fall on 11/13/21, and V19 did not see R7 prior to the fall. On 12/2/21 at 9:56 AM V4 Certified Occupational Therapy Assistant/Rehab Director stated: R7 received Physical Therapy from 9/29/21 - 10/15/21. Upon discharge therapy recommended a supervised ambulation restorative program. Staff should be with R7 at all times when R7 is walking due to R7 being a fall risk and offer R7 frequent rest periods. On 12/2/21 at 10:38 AM V4 stated: V4 spoke with V17 Physical Therapist and prolonged weight bearing status meant R7 was constantly up walking. On 12/1/21: At 1:13 PM V2 Director of Nursing (DON) stated: Neurological assessments are to be completed for unwitnessed falls or if the resident hits their head. Initial Neurological assessments are documented in the fall note, and then after that the assessments are documented on the paper Neurological flow sheet. V2 stated V2 did not have any Neurological assessments to provide following R7's fall on 11/13/21. The nurses told V2 the assessments weren't done. At 2:26 PM V2 stated: Prior to R7's fall on 11/13/21 R7 would ambulate independently about the unit. R7's gait was shuffled at times and R7 was wearing tennis shoes with a lot of grip, so we had R7 start wearing nonskid socks instead of shoes. Fall risk assessment scores determine the resident's risk for falls. Residents who are high risk for falls have more narrowed specific fall prevention interventions on their care plan. On 12/1/21: At 3:50 PM V2 stated V2 was unable to provide any additional Neurological assessments for R7's falls on 10/24/21, 11/8/21, and 11/11/21. At 11:23 AM V2 stated R7 did not have any restorative programs implemented and confirmed R7's 10/24/21 and 11/8/21 Fall Risk Assessments were not completed accurately. At 11:58 AM V2 confirmed R7's 10/24/21 fall investigation did not document staff interviews/witness statements and did not document when R7 was observed or toileted before the fall. At 12:30 PM V2 stated the root cause of R7's fall on 11/13/21 was believed to be that R7 slipped in water on R7's bathroom floor. V2 would expect R7 to have on nonskid socks when ambulating. The 11/13/21 fall investigation only documented witness statements from V9 and V19. V2 confirmed there is no documentation in R7's medical record or fall investigation of when R7 was last observed or toileted, or if R7 had on nonskid socks prior to the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/1/21 at 1:52 PM V15 Nurse Practitioner stated: R7 has had several falls. On 11/15/21 V9 reported R7's November falls to V15 and requested V15 assess R7. V9 told V15 that R7 had not been acting right since R7's fall on 11/13/21. R7 had bleeding/redness to R7's right eye and bruising to R7's right cheek. The bleeding of R7's eye was very concerning since R7 is on Eliquis and had fallen. R7 was admitted to the hospital with an intraventricular hemorrhage. If a resident is on anticoagulants and has an unwitnessed fall V15 likes to see them sent to the emergency room for evaluation, but V15 was not sure if that is the facility's policy. V15 would expect the nurses to complete post fall Neurological assessments for residents who have an unwitnessed fall and take an anticoagulant. On 12/2/21 at 11:17 AM V15 stated: V15 would expect R7's care plan intervention for nonskid gripper socks to be implemented. Gripper socks or shoes could have prevented R7's fall. 2. R8's Diagnosis List dated 12/8/21 documents R8 has diagnosis of Alzheimer's Disease. R8's MDS dated [DATE] documents: R8 has severe cognitive impairment, uses extensive assistance of two staff for transfers and extensive assistance of one staff for toileting. R8's Care Plan revised on 11/20/21 documents: R8 is at high risk for falls and was admitted to the facility after a fall that resulted in a Right Hip Fracture. This Care Plan documents interventions dated 11/22/21 to offer more frequent toileting as R8 desires and to keep the bed in low position. R8's Order Recap Report dated 11/1/21-12/1/21 documents an order for Enoxaparin Sodium (anticoagulant) 40 mg/0.4 ml (milliliters) inject 0.4 ml subcutaneously once daily for 28 days beginning on 11/11/21. R8's Nursing Notes document: On 11/19/21 at 8:01 PM R8 was found on the floor beside R8's bed. R8 was incontinent of urine and was believed to be attempting to self-toilet. On 11/25/21 at 1:15 PM R8 was yelling out and staff found R8's head and back on the floor, and R8's legs were in the bed. R8 stated R8 hit R8's head and was holding the right side of R8's head. R8's nursing notes document Neurological assessments were completed on 11/25/21 at 1:26 PM, and on 11/26/21 at 1:39 AM and 10:44 AM, following R8's fall on 11/25/21. R8's medical record does not contain a Neurological Flow Sheet for R8's falls on 11/19/21 and 11/25/21. R8's Fall Investigation dated 11/25/21 documents the root cause of R8's fall was believed to be that R8 changed position and slid off of R8's bed, and R8 uses an air mattress. R8's post fall intervention was to place a draw sheet on R8's bed when R8 is lying in bed to prevent sliding. This investigation contained V8 LPN's witness statement that documents R8 had a small bump to R8's right side of scalp. R8 was assisted back into bed and R8's bed was positioned low to the floor. There is no documentation any other staff besides V8 were interviewed, when R8 was checked on or toileted prior to R8's fall, or that R8's air mattress setting was evaluated. On 12/1/21: At 9:35 AM R8 was lying in bed on an air mattress with R8's feet dangling over the side of the bed. R8's bed was not positioned low to the floor. At 10:55 AM, 12:02 PM, and 12:57 PM R8 was lying in bed and R8's bed was elevated, and not low to the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/1/21 at 12:21 PM V8 LPN stated: (On 11/25/21) R8 was yelling out in R8's room. R8 was found with R8's back and head on the floor and R8's feet in the bed. R8's bed was not low to the floor at the time of R8's fall. That wasn't the first time R8 has fallen, and R8's bed should be low to the floor. I assessed R8 and R8 had a goose egg to R8's top right forehead. I checked R8's pupils, speech, hand grasps, level of consciousness, and vitals following R8's fall. Post fall Neurological assessments are to be completed every 15 minutes for 1 hour, then every 30 minutes for an hour, then every 4 hours for 24 hours. We use a paper form to document Neurological assessments that is passed on from shift to shift. On 12/2/21: At 11:10 AM V14 RN stated R8's 11/19/21 post fall intervention was for R8's bed to be in low position near the floor. At 11:31 AM V14 RN confirmed V8's witness statement was the only interview conducted for R8's 11/25/21 fall investigation. V14 confirmed the investigation does not document when R8 was last checked on or toileted, or that R8's air mattress setting was evaluated. On 12/1/21 at 3:50 PM V2 DON stated V2 was unable to provide additional documentation of post fall Neurological assessments for R8's 11/19/21 and 11/25/21 falls. The facility's Fall Prevention Program revised July 2021 documents: 3. Risk factors causing the fall should be identified such as: a. Lightheadedness or Dizziness, multiple medications, Musculoskeletal abnormalities, Peripheral Neuropathy, Gait and Balance Disorders, Cognitive Impairment, weakness, environmental hazards, confusion, visual impairment, and illnesses affecting the central nervous system and blood pressure. 4. Identify the root causes of the fall incident which could be related to resident's current or declining medical condition or worsening behavior. Staff will attempt to determine possible root causes of falls. Collect and evaluate any information until either the cause of the falling is identified or can be speculated as to what was the resident trying to do causing the fall, or it is determined that the cause cannot be found or that finding a cause would not change the outcome or the management of falling and fall risk. Follow up on any falls with associated injury until the resident is stable and complications such as fracture or subdural hematoma have been ruled out or resolved. a. Delayed complications such as late fractures and major bruising may occur hours or several days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall. The facility's Neurological Evaluation policy revised March 2021 documents: The purpose of this procedure is to provide guidelines for a Neurological evaluation: 1. When following an unwitnessed fall; 2. Fall with injury to face and/or head; or 3. When indicated by resident condition. 1. When assessing Neurological status, always include frequent vital signs. 2. Any change in vital signs and/or Neurological status in a previously stable resident should be reported to the Attending Physician. Neurological assessment includes determining the resident's orientation to person, place and time, observing patterns of speech and clarity, monitoring temp, pulse, respirations, and blood pressure, checking bilateral pupil reaction, assessing bilateral strength and asking resident to squeeze fingers, assessing bilateral feet movement and determining if the resident has any numbness or tingling. Have the resident smile to determine if there is any facial drooping. Document findings in the resident's record.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 35046 Based on observation, interview, and record review the facility failed to prevent the potential cross contamination of indwelling catheter tubing and a urine collection bag by failing to prevent the tubing and bag from touching the floor. This failure had the potential to affect one (R6) of three residents reviewed for Urinary Tract Infections on the sample list of eight residents. Findings include: The facility's Urinary Catheter Care policy with a revision date of May 2021 documents under the heading of Infection Control that, c. Be sure the catheter tubing and drainage bag are below the resident's bladder and kept off of the floor. On 11/29/21 at 11:00 AM, R6 was sitting up in a wheelchair in R6's room. V21 Physical Therapy Assistant was present in the room. R6's urine collection bag was uncovered and was lying flat on the floor. V21 stated V21 just transferred R6 into the wheelchair. V21 then picked the urine collection bag up off of the floor and hung it underneath the wheelchair. The urine collection bag was touching the floor along with the indwelling catheter tubing. V21 then left the room. On 12/2/21 at 11:22 AM, R6's urine collection bag and indwelling catheter tubing was touching the floor. On 12/2/21 at 11:30 PM, V2 Director of Nursing stated urine collection bags nor tubing should touch the floor. On 12/6/21 at 11:07 AM, R6's urine collection bag and indwelling catheter tubing was touching the floor. V3 Wound Nurse was present and confirmed the collection bag and tubing was lying on the floor.