STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145701	A. BUILDING _____ B. WING _____	C 07/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA TERRA STREAMWOOD	**815 EAST IRVING PARK ROAD STREAMWOOD, IL 60107**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation 2193299/IL133859 - No deficiency 2193634/IL134284 - No deficiency 2183702/IL134367 2184086/IL134863 2194390/IL135248	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		7/22/21

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

Electronically Signed | 07/23/2021

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.

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F 580	Continued From page 1 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to immediately inform a resident's physician of an accident to obtain orders for potential physician intervention and failed to immediately inform a resident's family of an accident involving one (R2) of four residents reviewed for change in condition. Findings include: R2 was a 70 year old cognitively-impaired resident with diagnoses including but not limited to vascular dementia with behavioral disturbance, right leg below the knee amputation, and end stage renal disease. On 6/30/21 at 10:10 AM, V2 (Director of Nursing)	F 580	Bella Terra Streamwood 815 E. Irving Park Road Streamwood, Illinois 60107-3073 Date of Survey: 07/03/2021 Plan of Correction Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of the truth of the facts alleged of the convictions set forth in the statement of deficiencies required by the provisions of the federal and state law. F580 Notify of Changes (Injury/Decline/Room, etc.) 1. Corrective actions which will be accomplishedfor those residents found to have been affected by the deficient	

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F 580	Continued From page 2 stated, "(R2) was found unresponsive by the nurse (V11/Registered Nurse/RN) at around 6:00 in the morning and wasn't informed by the previous nurse (V12) that R2 had fallen so he didn't continue any neuro-checks (brief neurological exam) on him which the nurse (V11) should have continued. He also did not call the doctor or family." On 6/30/21 at 11:45 AM V12 (RN) stated, "(R2) was found on the bathroom floor in an empty bedroom at the end of the hall. I was the only nurse on duty and was at the opposite end of the unit from where R2 was. V18 (Certified Nursing Assistant/CNA) told me she found R2 on the bathroom floor and there was stool on the toilet bowl. I tried to do an assessment of R2 and check him for injuries, but he is confused so he couldn't tell me what happened. We put him back in his wheelchair and brought him back to his room and put him back to bed. I started neuro-checks on him." Surveyor asked if he informed the doctor of R2's unwitnessed fall to obtain further orders. V12 stated, "I didn't call the doctor or the family because the phones weren't working. I also forgot to endorse (inform) to the next shift nurse (V11) about the fall incident." Nursing progress note by V12 (RN) on 6/11/21 at 7:51 PM stated in part, "This is a late entry of incident on June 10, 2021 at about 8:30 PM to allow for further investigation. As per CNA report, resident was noted calling for help. Staff went immediately to the resident to check. Resident was noted inside the washroom. Resident was in sitting position beside the toilet bowl facing the door. Head to toe assessment done. No visible	F 580	practice. R2 has been discharged from the facility since 06/11/2021. 2. The facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this alleged deficient practice. 3. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and not recur. The Director of Nursing and Clinical Managers completed audit on 7/16/2021 of all resident with falls and change of condition to ensure notification of attending physician, family/representative and facility leadership is proper and promptly done. (See Exhibit F580-A) V 12 received one on one in-service and counseling from the Director of Nursing/Administrator on 06/11/2021 regarding the Fall Occurrence Policy and Notification for Change of Condition. (See Exhibit F580-B) The Director of Nursing and designee completed an in-service with all Licensed Nursing Staff on 07/15/2021 regarding policy of Notification for Change of Condition with focus on notifying resident's attending physician, family/representative and facility leadership immediately after an incident and/or change of condition of a resident. (See Exhibit F580 - C) The Director of Nursing and Clinical Managers completed an all staff in services on 6/11/2021 and all Licensed Nursing Staff on 7/15/2021 regarding Fall	

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F 580	Continued From page 3 injuries or bumps noted. Neuro-check every 15 minutes was initiated with resident denying pain when asked upon each assessment. Resident was assisted back to the wheelchair. Resident was assisted back to bed. Neuro-check was continued, initial blood pressure was elevated 172/111 at about 8:30 PM. Blood pressure was monitored and it went down to 139/79 at about 8:45 PM. Resident with no further complaints and slept until the end of the shift." There was no nursing entry written by V12 to show he informed the doctor, family, or any facility staff member of the of R2's unwitnessed fall incident. On 6/30/21 at 1:35 PM, V11 (RN) stated, "When I started my shift that night at around 11:20 (PM) I didn't get a report from the previous nurse (V12) who was on duty, and he already left the building and he never told me that R2 fell earlier. So I didn't conduct any neuro-checks or was told anything that happened to him. I found (R2) at 6 AM and he was unresponsive and was drooling. I immediately checked his blood sugar because I knew he was diabetic and received dialysis. I then called 911 and when the paramedics came, I overheard them saying he's already gone." Emergency Medical Services record dated 6/11/21 stated in part, "Responded for the full arrest at facility. Upon arrival paramedics assessed patient to determine no further resuscitation was needed and medical control contacted for a time of death. Scene/body left in care of Police Department Officers."	F 580	Occurrence Policy. (See Exhibit F580- D) 4. Quality Assurance Plan The Director of Nursing/Designee will continue to complete an audit of all residents with incidents and change of condition 2x/week for 6 weeks to ensure that physician, family/representative, and facility leadership were notified properly and promptly. (See Exhibit F580-E) The result of this audit will be presented at the Quality Assurance and Performance Improvement Meeting. Completion Date: July 22, 2021	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		7/22/21

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F 656	Continued From page 4 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		

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F 656	Continued From page 5 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow care plan interventions and to have specific, resident-centered care plan interventions in place to address residents assessed to be at risk for falls. This failure resulted in one resident (R1) sustaining a knee fracture due to a fall from bed and (R2) having an unwitnessed fall. Findings include: 1. R1 is an alert and oriented 84 year old with diagnoses including but not limited to Parkinson's disease, Alzheimer's disease, and chronic obstructive pulmonary disease. Care plan revised on 5/19/21 by V17 (Restorative Nurse Director) states (in part), "Resident requires assistance with activities of daily living (bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting). Bed mobility maximum assist." Fall risk assessment dated 6/23/21 documents R1 with a score of 19, which is considered high risk for falls. There were no prior fall risk assessments shown in the records or provided to surveyor. On 7/1/21 at 11:45 AM, V17 stated, "(R1) required a 2-person staff assist to turn left and right while in bed. She is limited in her ability to scoot up the bed and she still needs that 2-person assist. I was informed of her fall out of	F 656	Bella Terra Streamwood 815 E. Irving Park Road Streamwood, Illinois 60107-3073 Date of Survey: 07/03/2021 Plan of Correction Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of the truth of the facts alleged of the convictions set forth in the statement of deficiencies required by the provisions of the federal and state law. F656 Develop/Implement Comprehensive Care Plan I. Corrective actions which will be accomplishedfor those residents found to have been affected by the deficient practice. n R2 has been discharged from the facility since 06/11/2021. RI was readmitted to the facility on 07/09/2021 and risk for fall was re-assessed to address RI 's risk to fall. RI 's care plan was reviewed and updated to ensure interventions established is resident-centered. (See Exhibit F656-A) 2. The facility will identify other residents having the potential to be affected by the same deficient practice. All residents identified to be at risk for falls have the potential to be affected by this alleged deficient practice. 3. The measures thefacility will take or	

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F 656	Continued From page 6 bed and was told she slid out of bed, but we did not consider her a fall risk. There should have been 2 certified nursing assistants when they were changing her brief, but I did hear there was only one aide. It's possible that the bed was high up when she was being changed and that only one aide had to roll her to her side so that's when she rolled out of bed and fell to the ground. I do not believe she slid to the floor given her injury." A care plan written on 3/25/21 by V10 (Fall Prevention Nurse) documents R1 to be at high risk for falls and states, "(R1) is high risk for falls related to Anxiety disorder, Cerebrovascular Accident (CVA), cognitive impairment, decline in functional status, depression, impulsivity or poor safety awareness. Interventions: Please make sure that my call light is within my reach and encourage me to use it for assistance as needed. I would like staff to address my needs with a prompt response to all requests for assistance." Emergency room records dated June 23, 2021 at 3:18 PM shows in part, "The patient (R1) is an 84 year old female who was dropped out of her bed this morning when they were attempting to change her brief. She rolled over and fell to the floor, complained of some discomfort to the lower back and buttocks. Diagnostic results: 1. Fracture /dislocation of the distal left femur/proximal tibia. (bone above knee/shin bone). Procedure: Fracture/Dislocation. Technique: attempted reduction with traction counter-traction as well as manipulation; without success. Critical Care Note: Patient is unstable at presentation and required my full and direct attention, intervention and personal management for 60 minutes of critical time including time spend performing procedures. There is imminent risk of deterioration of the	F 656	systems the facility will alter to ensure that the problem will be corrected and not recur. The Director of Nursing and Clinical Managers completed audit on 7/16/2021 of all residents to identify residents who are at risk for falls and the level of assistance on Activities of Daily Living. A list of residents will be posted in each nurses' station and will be updated on weekly and as needed. (See Exhibit F656-B) The Director of Nursing and Clinical Managers reviewed care plan interventions of all residents identified to be at risk to fall to ensure interventions are resident centered on 7/21/2021. (See Exhibit F656-C) The Director of Nursing and Clinical Managers completed inservices to all staff regarding the availability of the list at the nurses' station on 7/6/2021 and 7/19/2021. (See Exhibit F656-D) The Director of Nursing and Clinical Managers initiated inservices on 7/15/2021 and 7/19/2021 to all staff regarding implementation of interventions established in resident's care plan at all times. (See Exhibit F656- E) 4. Quality Assurance Plan " The Director of Nursing/l)esignee will do random check and observations of 5 residents 3x/week for 8 weeks to ensure that interventions in place is residentcentered and implemented always. (See Exhibit F656-F) " The result of this audit will be presented at the Quality Assurance and Performance Improvement Meeting.	

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F 656	Continued From page 7 cardiovascular systems." 2. R2 was a 70 year old cognitively-impaired resident with diagnoses including but not limited to vascular dementia with behavioral disturbance, right leg below the knee amputation, and end stage renal disease. Care plan dated 3/22/21 states (in part), "(R2) is high risk for falls related to cognitive impairment, decline in functional status, impaired balance during transitions, missing limbs. Interventions: Bed/chair alarm to alert staff when resident attempts to get out of bed/chair unassisted, so staff can assist resident and prevent falls; visually check me every hour, or more frequently as determined by care team." Records show R2 with previous unwitnessed falls that occurred on 3/21/21 when R2 was found on the floor beside his bed, and on 4/6/21 when R2 was again found on the floor beside the bed. There were no records to support R2 was visually checked on every hour or more per documented care plan interventions. On 6/30/21 at 11:45 AM V12 (Registered Nurse/RN) stated, "(R2) was on the bathroom floor in an empty bedroom at the end of the hall. I was the only nurse on duty and was at the opposite end of the unit from where R2 was found. V18 (Certified Nursing Assistant/CNA) told me she found R2 on the bathroom floor and there was stool on the toilet bowl. I tried to do an assessment of him and check him for injuries, but he is confused so he couldn't tell me what happened. We put him back in his wheelchair and brought him back to his room and put him back to bed. I started neuro-checks (brief	F 656	Completion Date: July 22, 2021	

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F 656	Continued From page 8	F 656		

neurological exams) on him." Surveyor asked if he heard any alarm go off that drew him to find R2. V12 stated, "No, he was heard yelling for help and V18 went in and saw (R2) on the ground in the bathroom. She called me to tell me and we picked him up from the ground back to his wheelchair." Surveyor asked what fall prevention measures were in place for R2. V12 stated, "I know he's a fall risk and has to be supervised. We just have to watch him more closely, that's all."

On 6/30/21 at 1:35 PM, V11 (RN) stated, "When I started my shift that night at around 11:20 (PM) I didn't get a report from the previous nurse (V12) who was on duty. He already left the building and he never told me that R2 fell earlier, so I didn't conduct any neuro-checks or told anything about what happened to him (R2). I found (R2) at 6 AM. R2 was unresponsive and was drooling, so I immediately checked his blood sugar because I knew he was diabetic and receives dialysis. I called 911 and when the paramedics came, I overheard them saying he's already gone."

On 7/1/21 at 11:00 AM V2 (Director of Nursing) stated, "We don't have any specific care plan policy, just a general care policy."

Facility policy addressing care planning of residents dated 8/5/20 and titled "General Care" states in part, "It is the facility's policy to provide care for every resident to meet their needs. Upon admission or readmission, the facility will evaluate the resident for physical and psychosocial needs. The facility will assist the resident to meet these needs, unless it shows that the resident's needs cannot be met in the facility. During the resident's stay at the facility, the resident may be evaluated

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F 656	Continued From page 9 to determine that need if there is a change in condition."	F 656		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: These failures resulted in two deficient practice statements. 1. Based on observation, interview, and record review, the facility failed to follow their care plan interventions to monitor and supervise a cognitively impaired resident with a history of falls and failed to follow the facility's fall policy of implementing interventions for a personal bed and/or wheelchair alarm device. These failures affect one (R2) of four residents reviewed for falls and resulted in R2 having an unwitnessed fall, then not being monitored according to the plan of care. R2 was subsequently found unresponsive and pronounced dead at the facility. 2. Based on observation, interview, and record review, the facility failed to provide required assistance with bed mobility during incontinence care for one (R1) of four residents in the sample. This failure resulted in R1 rolling out of bed and sustaining a knee fracture and emergent transfer to an acute care hospital.	F 689	Bella Terra Streamwood 815 E. Irving Park Road Streamwood, Illinois 60107-3073 Date of Survey: 07/03/2021 Plan of Correction Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of the truth of the facts alleged of the convictions set forth in the statement of deficiencies required by the provisions of the federal and state law. F689 Free of Accident Hazards/Supervision/Devices 1. Corrective actions which will be accomplishedfor those residents found to have been affected by the deficient practice R2 was discharged from the facility on 06/11/2021. RI 's bed mobility assistance was re-evaluated by Physical Therapist on 7/10/2021 , Occupational Therapist on	7/22/21

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F 689	Continued From page 10 Findings include: 1. R2 was a 70 year old cognitively-impaired resident with diagnoses including but not limited to vascular dementia with behavioral disturbance, right leg below the knee amputation, and end stage renal disease. Care plan dated 3/22/21 states in part: (R2) is high risk for falls related to cognitive impairment, decline in functional status, impaired balance during transitions, missing limbs. Interventions: Bed/chair alarm to alert staff when resident attempts to get out of bed/chair unassisted, so staff can assist resident and prevent falls; visually check me every hour, or more frequently as determined by care team; make sure that my call light is within my reach and encourage me to use it for assistance as needed." Records document R2 with a previous unwitnessed fall that occurred on 3/21/21 where R2 was found on the floor beside the bed and on 4/6/21 where R2 was again found on the floor beside the bed. On 6/30/21 at 10:10 AM, V2 (Director of Nursing) stated, "(R2) was found unresponsive by the nurse (V11/Registered Nurse/RN) at around 6:00 in the morning and wasn't informed by the previous nurse (V12) that R2 had fallen. (V11) didn't continue any neuro-checks (brief neurological exam) on the resident which the nurse (V11) should have continued. He also didn't inform the doctor or the family {of the fall}." On 6/30/21 at 11:45 AM V12 (RN) stated, "(R2) was on the bathroom floor in an empty bedroom	F 689	7/15/2021 and Restorative Nurse on 7/12/2021. (See Exhibit F689-A) RI is receiving physical and occupational therapy to ensure RI reaches the highest practicable functional level. RI will receive proper assistance with bed mobility for incontinence care as established in the care plan. 2. Thefacility will identify other residents having the potential to be affected by the same deficient practice Residents who require assistance with bed mobility or who are high fall risk have the potential to be affected by this alleged deficient practice. 3. The measures thefacility will take or systems thefacility will alter to ensure that the problem will be corrected and not recur The Restorative Nurse and Fall Prevention Coordinator completed an audit of all residents who are high risk for falls and all residents and the level of assistance on bed mobility on 7/21/2021. List is established and posted in each of the nurses' station. (See Exhibit F689-B) The Director of Nursing and Clinical Managers completed in services on 7/19/2021 to all nursing staff regarding the availability of the list. (See Exhibit F689-C) Nursing staff was re-educated and in-serviced by the clinical managers on 7/19/2021 on following residents' care plan to ensure that proper assistance is provided with bed mobility, incontinence care, supervision of cognitively impaired residents with a history of falls and implementing proper interventions for	

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F 689	Continued From page 11 at the end of the hall. I was the only nurse on duty and was at the opposite end of the unit from where R2 was found. V18 (Certified Nursing Assistant/CNA) told me she found R2 on the bathroom floor and there was stool on the toilet bowl. I tried to do an assessment of R2 and checked him for injuries, but he is confused so he couldn't tell me what happened. We put him back in his wheelchair and brought him back to his room and put him back to bed. I started neuro-checks on him." Surveyor asked if he heard any alarm go off that drew him to find R2. V12 stated, "No, he was heard yelling for help and V18 went in and saw (R2) on the ground in the bathroom and so she called me to tell me and we picked him up from the ground back to his wheelchair." Surveyor asked if he informed the doctor of R2's unwitnessed fall to obtain further orders. V12 stated, "I didn't call the doctor or the family because the phones weren't working. I also forgot to endorse (inform) to the next shift nurse (V11) about the fall incident." Surveyor asked what fall prevention measures were in place for R2. V12 stated, "I know he's a fall risk and has to be supervised. We just have to watch him more closely that's all." On 6/30/21 at 1:35 PM, V11 (RN) stated, "When I started my shift that night at around 11:20 (PM) I didn't get a report from the previous nurse (V12) who was on duty and he already left the building. V12 never told me that R2 fell earlier, so I didn't conduct any neuro-checks or was told anything that happened to him. I found (R2) at 6 AM and he was unresponsive and was drooling. I immediately checked his blood sugar because I knew he was diabetic and received dialysis. I then called 911 and when the paramedics came, I overheard them saying he's already gone."	F 689	residents who are fall risks. (See Exhibit F689-D) 4. Quality Assurance plans to monitorfacility performance to make sure that the corrective actions are achieved andpermanent: " The Director of Nursing or Designee will utilize a QA tool to ensure compliance with this POC. " The Director of Nursing or designee will complete random checks and observations of 5 residents who require assistance with bed mobility or who are high fall risks to ensure that interventions related to fall risk and level of assistance on bed mobility as established in the care plan are being implemented at all times. This QA will be completed 3x/week for 12 weeks. (See Exhibit F689-E) " The results of the monitoring and audits done under this POC will be submitted to the QAPI Committee for review and follow up. Date of Completion: July 22, 2021	

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F 689	Continued From page 12 Nursing progress note by V12 (RN) on 6/11/21 at 7:51 PM (written over 13 hours after R2's death) stated in part, "This is a late entry of incident on June 10, 2021 at about 8:30 PM to allow for further investigation. As per CNA report, resident was noted calling for help. Staff went immediately to the resident to check. Resident was noted inside the washroom. Resident was in sitting position beside the toilet bowl facing the door. Head to toe assessment done. No visible injuries or bumps noted. Neuro-check every 15 minutes was initiated with resident denying pain when asked upon each assessment. Resident was assisted back to the wheelchair. Resident was assisted back to bed. Neuro-check was continued, initial blood pressure was elevated 172/111 at about 8:30 PM. Blood pressure was monitored and it went down to 139/79 at about 8:45 PM. Resident with no further complaints and slept until the end of the shift." There were no nursing entries written by V12 (RN) to show that he immediately informed the doctor, family, or any facility staff member of the of R2's unwitnessed fall incident that occurred on his shift. Emergency Medical Services record dated 6/11/21 at 6:11 AM stated in part, "Responded for the full arrest at facility. Upon arrival paramedics assessed patient to determine no further resuscitation was needed and medical control contacted for a time of death. Scene/body left in care of Police Department Officers." Policy dated 8/2020 titled "Fall Occurrence" states in part, "It is the policy of the facility to ensure that residents are assessed for risk for	F 689		

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F 689	Continued From page 13	F 689		

falls and interventions are put in place to prevent the resident from falling. Those identified as high risk for falls will be provided interventions to prevent falls. If a resident had fallen, the resident is automatically considered as high risk for falls. An incident report will be completed by the nurse each time a resident falls. The falls coordinator will review the incident report and may conduct his/her own fall investigation to determine the reasonable cause of fall."

2. On 7/1/21 at 11:20 AM, V2 (Director of Nursing) stated, "We had a fall incident (6/23/21) that I reported to your office regarding (R1). She (R1) is currently in the hospital and we are aware that she got a fracture. V16 (Certified Nursing Assistant/CNA) was changing her brief and (R1) was in a side-lying position when she asked to get some more lotion put on her legs. When V16 reached for the lotion, R1 slid down from the bed and fell to the floor. There was only V16 in the room with her as she only needs one person assist for bed mobility."

Facility incident report completed by V10 (Falls Prevention Nurse) wrote (in part), "At around 4:40 am, CNA (V16) was changing resident's brief while resident was in bed. Resident was positioned on her right side and had asked the CNA to apply more lotion on her legs before lying on her back. While CNA reached for the lotion, resident was observed sliding off the side of the bed landing on her buttocks. Nurse on duty was notified immediately and upon entering the room, resident was observed sitting on the floor on the right side of her bed with head resting on the side of the bed. Head to toe and range of motion assessments were completed, resident complained of pain to left hip area. 911 was

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F 689	Continued From page 14	F 689		

called. Hospital follow-up was done, and resident was admitted with diagnosis of left knee fracture."

V16 (CNA) was not available for interview and did not return any calls from surveyor and V2.

R1 is an alert and oriented 84 year old with diagnoses including but not limited to Parkinson's disease, Alzheimer's disease, and chronic obstructive pulmonary disease.

MDS (Minimum Data Set) dated 4/15/21 documents R1's bed mobility required a 2-person staff assistance to turn and reposition while in bed.

Fall risk assessment dated 6/23/21 documents R1 with a score of 19 and considered high risk for falls (according to the risk assessment provided). There were no prior fall risk assessments shown in the records or provided to surveyor.

Care plan revised on 5/19/21 by V17 (Restorative Nurse Director) documents, "Resident requires assistance with activities of daily living (bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting). Transfers with mechanical lift & 2-person assist from bed to wheelchair. Bed mobility maximum assist."

On 7/1/21 at 11:45 AM, V17 stated, "(R1) required a 2-person staff assist to turn left and right while in bed. She is limited in her ability to scoot up the bed and she still needs that 2-person assist. I was informed of her fall out of bed and was told she slid out of bed, but we did not consider her a fall risk. There should have been 2 CNA's (Certified Nursing Assistants) when they were changing her brief. I did hear that there

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F 689	Continued From page 15 was only one aide. It's possible that the bed was high up too when she was being changed. The one aide had to roll her to her side so that's when she rolled out of bed and fell to the ground. I do not believe she slid to the floor given her injury." Emergency room records dated June 23, 2021 at 3:18 PM documents in part, "The patient (R1) is an 84 year old female who was dropped out of her bed this morning when they were attempting to change her [brief]. She rolled over and fell to the floor, complained of some discomfort to the lower back and buttocks. Diagnostic results: 1. Fracture/dislocation of the distal left femur/proximal tibia (bone above knee/shin bone). Procedure: Fracture/Dislocation. Technique: attempted reduction with traction counter-traction as well as manipulation; without success. Critical Care Note: Patient is unstable at presentation and required my full and direct attention, intervention and personal management for 60 minutes of critical time including time spend performing procedures. There is imminent risk of deterioration of the cardiovascular systems."	F 689		