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ROSEWOOD CARE CENTER OF EDWARDSVILLE	**6277 CENTER GROVE ROAD EDWARDSVILLE, IL 62025**

(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 Annual Licensure and Certification Survey	F 000		
F 223 SS=G	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure that residents are free from abuse for one of two residents (R19) reviewed for staff abuse, in the supplemental sample. This abuse resulted in (R19) being kicked and sustaining a leg wound and being frightened. Findings include: 1. The Minimum Data Set (MDS) dated 10/3/15 documents R19's cognition to be intact. The MDS documents R19 requires extensive assist of two staff for toileting and transfers. An Incident/Accident Report, dated 1/14/16 at 9:00 PM, completed by E16 Registered Nurse (RN), documented "Heard resident yelling, entered her room and resident alleged CNA (Certified Nurses Aide, E15) kicked her on her legs. Observed hematomas on bilateral lower extremities and skin tear on L (lower) shin." The	F 223		

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

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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report documented E15 was sent home immediately and the physician and family member (Power of Attorney over healthcare) were notified.

The Final Incident Report, dated 1/20/15, documents R19 as a 98 year old female who is alert/oriented and able to make her needs known. The Report narrative documents R19 stated she was sitting on the toilet and the CNA told her to get up off the toilet and R19 told the CNA she needed help. The report documents R19 stated the CNA was putting her hands up in her face and that she turned her head to avoid being hit. The Report documented R19 told E16 that E15 kicked both of her legs and that E15 put her roughly in the wheelchair. The report documents R19 then started screaming and the nurse came into her room. The Report documented E16 told E1, Administrator, that she heard R19 screaming for help and entered her room to find her in her wheelchair by the bed crying and that R19 told her E15 kicked her legs. The Report documented E16 stated R19 had hematomas to both legs and a skin tear to the left lower leg. The Narrative Report documents that E1 spoke with E18, RN/ Night Nurse and E18 reported that R19 provided the same information as she did earlier. E18 stated R19 reported to her that the CNA kicked her legs hard and E18 confirmed bruising to bilateral legs with a small skin tear on the left lower leg.

On 4/22/16 at 11:20 AM, R19 recalled the 1/14/16 incident and shaking her head stated "I screamed bloody murder as she stood in the doorway with her hands on her hips." R19 stated the CNA made a "real ugly face and made fists" stating "I thought (E15) was going to hit me so I turned my

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head." R19 stated E15 was hateful and she was "very afraid after that." R19 stated she still "had a hole in her leg from being kicked and now sees the wound clinic for it." R19 was sitting in her wheelchair at bedside and had a dressing on her left lower leg.

Wound documentation dated 4/19/16 describes R19's leg wound as "full thickness wound to the left lateral lower leg s/p (status post) hematoma c overlying tissue death and necrosis." The wound measures 4.2 centimeters (cm) x 3.1 cm with a circumferential area of undermining measuring 0.5 cm.

On 4/22/16 at 3:15 PM, E1 Administrator stated R19 was "really really shook up" after the incident, "wouldn't come out of her room, wouldn't eat, wouldn't talk to anyone, put herself into this shell, and still to this day, talks about it." E1 confirmed E15 was terminated due to resident's injury being consistent with the residents claim of abuse after being kicked.

On 4/26/16 at 9:45 AM, Z2, Medical Doctor/Facility Medical Director, stated R19 was "irritated" when he saw her after the incident. Z2 stated R19's lower leg had a large hematoma which was soft to touch when he first saw it but later opened up, got infected and is still being treated thru the wound clinic at this time. Z2 confirmed that he'd been notified and that the facility terminated the employee upon completing their investigation.

The facility's policy entitled "Abuse Prevention Policy" dated 3/2011 documents "This facility believes that each resident has the right to be free from abuse, neglect, corporal punishment,

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F 223	Continued From page 3 misappropriation of their property, and involuntary seclusion." The policy documents the definition of Abuse as "Physical Abuse - the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment."	F 223		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		

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F 225	Continued From page 4 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify local law enforcement of a suspicion of crime for one of two residents (R19) reviewed for staff abuse in the supplemental sample . Findings include: 1. An Incident/Accident Report completed by E16 Registered Nurse (RN) documented on 1/14/16 at 9pm that she "Heard resident yelling, entered her room and resident alleged CNA (Certified Nurses Aide) kicked her on her legs. Observed hematomas on bilateral lower extremities and skin tear on L (lower) shin." The report identified E15 as the Certified Nurses Aide (CNA) and was sent home immediately with the physician and family member (Power of Attorney over healthcare) notified. Local Law Enforcement was not documented as being notified. The "Final Report on Incident" with R19 dated 1/20/16 documents E1 interviewed R19 following the incident on 1/14/16 and R19 "stated that she did not want the police notified that she just did not want that CNA back in her room." The Report also documents E15 was terminated due to the	F 225		

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F 225	Continued From page 5 residents injuries being consistent with the allegations of being kicked. On 4/22/16 at 11:20 AM , R19 recalled the 1/14/16 incident but stated "I'm 98 years old and don't remember if I asked them not to call the police or not at that time." On 4/22/16 at 3:15 PM, E1 Administrator stated R19 was "really really shook up" after the incident but stated R19 did not want the police called. E1 stated R19 is alert and oriented and can make her own decisions, therefore the police were not notified. E1 confirmed that E15, CNA was terminiated due to R19's injuries being consistent with her allegations of being kicked. E1 stated, Z1, R19's daughter, actually called the police later. On 4/26/16, E1 provided a police report on the 1/14/16 abuse incident. The intake report date is 2/5/16 and the person reporting the battery was Z1, R19's daughter.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to operationalize their policies for Abuse Prevention and Investigation for one resident of 2	F 226		

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(R19) reviewed for staff abuse in the supplemental sample.

Findings include:

The facility's policy entitled "Abuse Prevention Policy", dated 3/2011 documents "This facility believes that each resident has the right to be free from abuse, neglect, corporal punishment, misappropriation of their property, and involuntary seclusion." The policy documents the definition of Abuse as "Physical Abuse - the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment."

The facility's policy entitled "Abuse Investigation Policy", dated 5/2013, documents "ALL allegations of abuse possible physical, emotional, sexual, verbal, and/or misappropriation of property) will be reported in a timely manner to the state agency in accordance with current regulations. Additionally, local law enforcement will be contacted in accordance with current state and federal regulations."

The Incident Report, dated 1/14/15 at 9:00 PM, completed by E16, Registered Nurse (RN) documented "Heard resident yelling, entered her room and resident alleged CNA (Certified Nurses Aide - E15) kicked her on her legs. Observed hematomas on bilateral lower extremities and skin tear on L (lower) shin." The report identified E15 as the CNA and was sent home immediately with the physician and family member (Power of Attorney over Healthcare) notified. The local law Enforcement was not documented as being

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F 226	Continued From page 7 notified at this time. The "Final Report on Incident", dated 1/20/16, documents E1, Administrator, interviewed R19 following the incident on 1/14/16 and documented that R19 "stated that she did not want the police notified that she just did not want that CNA back in her room." The Report also documents E15 was terminated due to the residents injuries being consistent with the allegations of being kicked. On 4/22/16 at 3:15 PM, E1 stated R19 was "really really shook up" after the incident, "wouldn't come out of her room, wouldn't eat, wouldn't talk to anyone, put herself into this shell, and still to this day, talks about it." E1 confirmed E15 was terminated due to R19's injury being consistent with the residents claim of abuse and confirmed the local police had not been called due to R19's requesting them not to. E1 stated the family member of R19 notified the police at a later date. On 4/26/16, E1 provided a police report on the 1/14/16 abuse incident. The intake report date is 2/5/16 and the person reporting the battery was Z1, R19's daughter.	F 226		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312		

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Based on interviews, observations and record review, the facility failed to provide eating assistance for 3 of 5 residents (R6, R12 and R13) reviewed for activities of daily living assistance in a sample of 18.

Findings include:

1. The Admission Sheet documents R13 was admitted to the facility on 4/12/16 with a partial diagnosis of Dementia.

R13's Care Plan, dated 4/15/16, documents R13 as requiring some assistance for eating with interventions to assist to eat as necessary, monitor intake as necessary, and offer supplements as ordered.

R13's Minimum Data Set (MDS), dated 4/19/16, documents R13 as requiring set up/supervision for eating.

On 4/19/16, R13 was sitting in her wheelchair at the dining room table when her tray was delivered. She had a regular plate and utensils and was served lasagna, bread stick and lettuce salad. R13 was sitting across the table from E2, Certified Nurse's Aide, CNA. R13 struggled to eat, dropping food on her shirt and getting the spoon to her mouth with no food on it. R13 was positioned a distance away from the table making it difficult for her to reach her drinks. E20 sat doodling on a piece of paper and provided no cueing/encouragement and/or assistance to R13 as she struggled to eat. E13 ate her lasagna and bread stick and at 12:50 PM, E3, Assistant Director of Nurses (ADON) came by her table, grabbed R13's bib off and stated "all finished?" E3 kept walking and R13 pulled her salad bowl

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off the table and ate it as it sat on her chest. E3 returned a short time later and R13 was finishing the salad.

On 4/20/16 at 12:15 PM, R13's lunch tray was delivered. She had chicken and dumplings in a bowl and carrots in a small bowl. R13 was again positioned a distance away from the table and pulled the bowl of chicken dumplings off the table to eat it as it rested on her chest. Her carrots were out of reach. R13 was dropping food off her fork and bowl onto her bib then scooping the food off the bib to eat it. No staff assisted her or positioned her closer to the table for easier reach. At 12:31 PM, E24 CNA sat next to her and moved the carrots within reach.

2. On 04/19/16 at 11:45 AM, R6 was in the assisted dining room in a high back wheelchair. R6 eyes were closed and her head was down. At 12:10 PM, E20 sat next to R6 and cut up her lasagna and asked R6 if she was going to wake up and eat lunch. R6 continued to sleep. E20 then gently touched R6's shoulder and R6 then woke up. R6 did not attempt to feed herself. E20 attempted to feed her but R6 again lowered her head and closed her eyes. At 12:30 PM, R6 was still sleeping and had not eaten anything. E20 was doodling on the meal card at the table while R6 slept. At 12:45 PM, E20 asked R6 if she was thirsty several times. R6 was sluggish and drank small sips of lemonade. At 12:53 PM, R6 was taken back to her room. R6 consumed few bites of food and her dinner plate was virtually untouched, and very little fluids were consumed.

R6's Physician's Order Sheet (POS), dated

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F 312	Continued From page 10 04/09/16, documented R6 had the following diagnoses, in part as, Cerebrovascular Accident, Chronic Kidney Disease, Macular Degeneration and Diabetes Mellitus. It also documented R6 required assist with feeding. The MDS, dated 03/05/16, documented R6 required limited assist of one for eating. 3. R12's POS for April 2016 documented diagnoses, in part, to include dementia, arthritis and muscle wasting. The facility's Resident Weight Report for R12 documented a weight of 134.8 pounds on 11/5/15. The same report documented a weight of 127.2 pounds on 4/4/16. This report shows a weight loss of 7.6 pounds from November 2015 to April 2016. R12's Minimum Data Set (MDS), dated 1/25/16, documented R12 requires "supervision of one person physical" for eating. R12's Care Plan, dated 1/22/16, documented , in part, "Requires assistance with ADL's (Acts of Daily Living) due to arthritis pain. The same Care Plan documented, "Allow adequate time to eat; provide cues; encouragement. Feed (R12) remaining food items." The same Care Plan does not address R12's weight loss. On 4/19/17 at 12:05 PM, R12 was in bed, leaning to the left with eyes closed. R12's lunch tray was sitting on the bedside table. No employees were in R12's room. R12 was observed every 10 minutes from 12:50 PM until 1:30 PM, lying in the	F 312		

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F 312	Continued From page 11 same position, eyes closed, with tray at bedside, untouched. During these times, no employees were observed in R12's room assisting her with lunch. On 4/19/16 at 1:31 PM, E17, CNA, entered R12's room and removed her lunch tray. E17 stated as she left R12's room "She doesn't want to eat." R12 was still lying in bed, leaning to the left with her eyes closed.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interviews, observations and record review, the facility failed to provide pressure ulcer prevention interventions including timely turning and reposition for 2 of 5 residents (R8 and R13) reviewed for pressure ulcer prevention in a sample of 18. Findings include: 1. The Admission Sheet documents R13 was admitted to the facility on 4/12/16 with diagnosis of Dementia in part.	F 314		

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R13's Minimum Data Set (MDS) dated 4/19/16 documents R13 as requiring extensive assist of two for transfers and occasionally incontinent of bladder.

The Care Plan dated 4/15/16 documents R13 to be at risk for pressure ulcers with interventions for staff to assist and/or encourage resident to turn/reposition at frequent intervals as necessary, weekly skin checks, monitor for incontinence, and apply barrier cream after each episode in part.

On 4/20/16 at 9:37 AM, R13 was sitting at the nurse's station. She was observed at 9:50 AM, 9:59 AM, and 10:20 AM, remained in the same position. At 10:20 AM, R13 was taken directly to activities for bingo where she was observed to remain in her wheelchair at 10:30 AM, 10:40 AM, 10:45 AM, and 11:10 AM. At 11:31 AM, R13 was still sitting at the table for bingo after the activity was over. At 11:45 AM, R13 was in the assisted dining room sitting at her table for lunch. No toileting was done during this time frame. R13 was observed throughout lunch and at 12:45 PM, taken to her room by E24, Certified Nurse's Aide, where she was placed by her bed. R13 was observed at 1:00 PM, 1:15 PM in the same position At 1:17 PM, E11, CNA took R13 to the bathroom. R13's disposable incontinent brief was soaked with urine. R13 voided and was provided poor incontinent care before being placed back into her wheelchair. No barrier cream was evident on her skin and none was applied by E11. R13 had deep creases across her upper back thighs and across her buttocks and upper legs. Her coccyx and sacrum area were deep red.

On 4/26/16 at 10:00 AM, E2, Director of Nurses

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identified a time frame to be routinely turned and repositioned at least every two hours.

2. R8's MDS, dated 4/1/16, documents R8 as having severe cognitive impairment and requiring total assist of one staff for transfers. The MDS documents R8 as always being incontinent of urine with her indwelling catheter being removed recently.

R8's Pressure ulcer risk assessment identifies her to be a moderate risk for ulcers although she was documented on the Pressure Ulcer log as being admitted to the facility with a pressure ulcer on her coccyx and left heel.

R8's Care Plan, dated 4/17/16, documents her to currently have ulcers with interventions to check for incontinence, cleanse if wet or soiled, pressure ulcer mattress and wheelchair cushion, treatments as ordered and turn/reposition.

On 4/20/16 at 9:40 AM, R8 was out of her room in the area by the nurses station. She had protective boots on both lower legs. At 9:45 AM, E8 and E14 CNA transferred R8 to bed using a mechanical lift. R8 had a soaked brief on. E8 stated they transferred R8 to her wheelchair for breakfast around 6:30-6:45 AM earlier that morning. R8 had deep creases across both buttocks, upper thighs and across hips. R8 had a dressing on her coccyx/buttock area and a large purple/yellowish ulcer on her left heel.

On 4/20/16, from 11:45 AM until 2:00 PM, R8 was up in her wheelchair without any turning/repositioning and/or checking for incontinence, based on 15 minutes or less observation intervals.

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F 314	Continued From page 14 The policy entitled "Skin Care Prevention of Pressure Ulcers" dated 3/03 documents the facility will ensure the integrity of each resident's skin is maintained, and will utilize specific skin care protocols for those residents identified at risk for pressure ulcers. The policy documents that staff will monitor preventative protocols are consistently carried out.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interviews, observations and record review, the facility failed to provide timely toileting and adequate incontinent care for two residents of 8 (R8 and R13) reviewed for toileting and incontinent care in a sample of 18. Findings include: 1. The Admission Sheet documents R13 was admitted to the facility on 4/12/16 with diagnosis of Dementia and urinary tract infection in past. The Minimum Data Set (MDS) dated 4/19/16	F 315		

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F 315	Continued From page 15 documents R13 as requiring extensive assist of two for transfers and occasionally incontinent of bladder. The Care plan dated 4/15/16 documents R13 to be incontinent of bowel and bladder with interventions to monitor for incontinence and apply barrier cream after each episode in part. On 4/20/16 at 9:37 am, R13 was sitting at the nurses station. She was observed at 9:50 am, 9:59 am, and 10:20 am to remained in the same position. At 10:20 am, R13 was taken directly to activities for bingo where she was observed to remain in her wheelchair at 10:30 am, 10:40 am, 10:45 am, and 11:10 am. At 11:31 am, R13 was still sitting at the table for bingo after the activity was over. At 11:45 am, R13 was in the assisted dining room sitting at her table for lunch. No toileting and/or check and changing was done during this time frame. R13 was observed through out lunch and at 12:45 am, taken to her room by E 24, CNA where she was left parked by her bed. R13 was observed at 1pm, 1:15pm and at 1:17pm was taken to the bathroom by E11, CNA. R13 had a soaked paper brief on. R13 voided down her legs as she stood to transfer to the toilet. After R13 had voided, E11 wiped between her buttocks several times but failed to provide any cleansing to her buttocks, upper thighs, hips and groin/periarea which would have been in contact with urine. No cleansing was provided to her legs. No barrier cream was provided. On 4/26/16 at 10 am, E2 Director of Nurses identified a time frame to be routinely checked, changed and toileted as at least every two hours. 2. The MDS dated 4/1/16 documents R8 as	F 315		

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having severe cognitive impairment and requiring total assist of one staff for transfers. The MDS documents R8 as always being incontinent of urine with her foley being removed recently. The Admission Record documents R8 to have a history of urinary tract infections. The Pressure ulcer risk assessment identifies her to be a moderate risk for ulcers although she was documented on the Pressure Ulcer log as being admitted to the facility with a pressure ulcer on her coccyx and left heel. The care plan dated 4/17/16 documents her to currently have ulcers with interventions to check for incontinence, cleanse if wet or soiled, pressure ulcer mattress and wheelchair cushion, treatments as ordered and turn/reposition but does not reflect her history of Urinary tract infections.

On 4/20/16 at 9:40 am, R8 was out of her room in the area by the nurses station. At 9:45 am, E8 and E14 CNA transferred R8 to bed using a mechanical lift. R8 had a soaked brief on. E8 stated they transferred R8 to her wheelchair for breakfast around 6:30-6:45 am earlier that morning. The CNA's turned R8 to her right side and E8 wiped back to front with bowel movement on the disposable wipes. E8 then wiped front to back. No cleansing was done to the left hip, upper thighs, groin area. Later on 4/20/16, R8 was observed up in her wheelchair for lunch at 11:45 am and still in her wheelchair at 2pm (continual observations) without any checking/changing for incontinence.

The policy entitled "Incontinence Care" dated 6/11/08 documents the facility will provide cleansing after each episode of incontinence to prevent skin breakdown and dignity for all residents.

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide effective fall interventions for 3 of 10 residents (R3, R5 & R15) reviewed for falls in the sample of 18. Findings include: 1. On 04/19/16 at 9:45 AM, R15 was sitting in her wheelchair alone in her room. At 1:30 PM, R15 had propelled herself from the dining to her room and was near the bathroom door moving items around in her room. The Physician's Order Sheet (POS), dated 04/01/16, documented R15 had the following diagnoses, in part as, Dementia without Behavioral Disturbances, Senile Dementia, Symbolic Dysfunction, Syncope/Collapse, Abnormal Gait and Muscle Wasting. The Minimum Data Sheet (MDS), dated 01/20/16, documented R15 was moderately cognitively impaired and required extensive assist of one staff for transfers, dressing and toileting. It also documented R15 was frequently incontinent of bladder.	F 323		

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F 323	Continued From page 18 R15's Care Plan, dated 02/05/16, documented R15 has poor safety awareness and memory deficits with a history of falls. It also documented R15 will remove unsafe things from the nurses station, i.e. safety pins and scissors and take to her room. An Incident/Accident Report, dated 10/29/15 at 1:00 AM, documented R15 was found on the floor in her bathroom between the toilet and the wall. It documented R15 was attempting to self transfer and left knee gave out. The Post Investigations Actions were resident teaching and care plan review. R15's Care Plan was not updated to address this fall or inteventions to prevent future falls. An Incident/Accident Report, dated 01/26/16 at 11:30 PM, documented R15 was found on the floor next to her bed. It documented R15 gave three different stories as to what happened, stating "I believe I fell out of bed tonight." The Post Investigations Actions were resident teaching, Physical Therapy/Occupational Therapy (PT/OT) referral, implementation of new fall prevention and care plan review. R15's Care Plan was not updated to address this fall or inteventions to prevent future falls. An Incident/Accident Report, dated 01/27/16 at 6:00 PM, documented R15 was found in her room sitting on the floor in front of her wheelchair. It documented R15 slipped after getting up to urinate in the bathroom. It documented R15 was found with bare feet and a wet incontinent pad under her. The Post Investigations Actions were PT/OT referral, resident teaching, implementation of new fall prevention, care plan review and	F 323		

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F 323	Continued From page 19 non-skid socks at bedtime. An Incident/Accident Report, dated 01/29/16 at 10:30 PM, documented R15 was found in her room on the bathroom floor sitting between the toilet and the wall. It documented R15 stated she was attempting to get off the toilet and the wheelchair slid away from her. The Post Investigations Actions were PT/OT referral, resident teaching, implementation of fall prevention, care plan review and wheelchair alarm. An Incident/Accident Report, dated 02/13/16 at 11:30 AM, documented R15 was found in her room on the bathroom floor. It documented R15 stated she slipped on ball from a necklace. It further documented R15 was last seen in her wheelchair. There was no documentation as to whether the wheelchair alarm was sounding at this time. The Post Investigations Actions were to review the care plan. R15's Care Plan was not updated to address this fall and interventions were not updated to prevent future falls. On 04/22/16 at 3:15 PM, E2, Director of Nursing, stated that the resident teaching interventions would include reminding the resident to use the call light when needing assistance and not to get up unattended. On 04/26/16 at 10:00 AM, E2 also stated that the current Incident Reports did not have an area to document if alarms were sounding and/or staff were not documenting that a thorough review of the prior interventions was done to check the effectiveness of the interventions. 2. On 04/19/16 at 9:45 AM, R3 was sitting in her wheelchair in her room alone. At 11:45 AM, R3	F 323		

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was in the same position sitting in her wheelchair in her room. At this time, E20, Certified Nursing Assistant (CNA) was observed standing at the doorway of R3's room and stated "It's lunchtime sweetheart." At 12:00 PM, R3 propelled herself down the hall to the assisted dining room. At 12:10 PM, R3 was served a regular meal. At 12:55 PM, R3 propelled herself back down to her room.

The POS, dated 04/01/16, R3 had the following diagnoses, in part as, Parkinson's Disease, Diabetes Mellitus and Senile Dementia. On 04/01/16, a physician's order for a wheelchair positioning device/ Pommel cushion).

The MDS, dated 02/20/16, documented R3 was severely cognitively impaired with disorganized thinking and required extensive assist of at least one staff for bed mobility, transfers, toilet use, hygiene and bathing. It also documented R3 was always incontinent of both bowel and bladder.

The Care Plan, dated 03/02/16, documented R3 was severely cognitively impaired requiring extensive assist of at least one staff for activities of daily living. It also documented R3 has a communication deficit of only speaking Greek and only speaking very limited broken English. It also documented R3 was at risk for falls due to memory deficit, poor communication and dependent on staff for all cares.

An Incident/Accident Report, dated 11/29/15 at 3:31 PM, documented R3 was found on the floor on both knees by her bed with the wheelchair behind her. It documented that E25, CNA stated she had asked R3 if she needed to go to the bathroom and R3 said no. The Post

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Investigations Actions were to review the care plan and to instruct the CNA's to toilet R3 every two hours and not ask her if she needs to go.

An Incident/Accident Report, dated 12/12/15 at 1:50 PM, documented R3 was found on the floor between the toilet and the wall. E23, CNA stated that R3 had slid off the toilet to the floor. The Post Investigations Actions were staff in-servicing and care plan review. It also documented under "Commentary - R23, CNA educated not to leave R3 unattended on the toilet. CNA stated she was in R3's room but not standing in the bathroom and R3 impulsively got up. CNA heard noise but couldn't catch R3 in time."

On 04/26/16 at 10:15 AM, E23, CNA stated that the incident was hard to remember because it happened so long ago. She stated that she was giving R3 privacy in the bathroom and that she was standing in the room and heard her fall. E23 further stated that R3 would get up on her own every now and then. She stated R3 was a one assist with gait belt for transfer. E23 stated that "She's (R3) fine, she wasn't hurt."

An Incident/Accident Report, dated 03/23/16 at 10:45 AM, documented R3 was found on the floor in her room laying on her right side with her glasses in her hand. The Post Investigations Actions were implementing new fall prevention intervention, raised edge mattress and care plan review.

The Fall Risk Assessments policy and procedure, dated 09/03, documented under "The Rehab/Restorative Nurse will: 1. Collaborate with the Director of Nursing/Designee, the Facility Therapy Director and the Care Plan Nurse as

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necessary in order to determine the most appropriate and effective fall prevention measure for each resident when the Fall Risk Screening, Therapy Fall Risk Screening, 21 Day Assessment reveals the resident to be at risk for falls."

3. The MDS dated 10/24/15 documents R5 as having moderate cognitive impairment and requiring minimum assist of one staff for transfers and bed mobility. The MDS documents R5's ability to move between surfaces and to rise and sit as "only able to do with staff assist."

R5's Care Plan, dated 4/12/16, documents R5 at risk for falls with multiple falls in the past six months. Interventions include pommel cushion 3/3/15, anti roll wheelchair, call light within easy reach, keep personal items within easy reach, bed in low position, bed to wall, evaluate medication regime, proper fitting shoes, and respond promptly to call light for assist to toilet in part.

Incident reports document R5 had 6 falls from 11/12/15 thru 4/17/16.

R5's Incident/Accident Report, dated 11/12/15 at 2:00 PM, documents R5 was found on the floor on her side in the bathroom. No injuries were noted and the etiology of the fall was determined by the facility to be "unsafe transfer attempt by resident." Post investigation actions included resident teaching, care plan review/revision. R5's Care Plan was revised to address this fall or interventions implemented to prevent future falls.

An Incident/Accident Report, dated 12/17/15 at

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F 323	Continued From page 23 7:40 AM, documents R5 was found sitting on the floor upright in her bathroom saying she was trying to go to the toilet. The report documents no call light on at the time and R5 had no pain complaints. Etiology of the fall was undetermined, care plan review/revision as done and a urinalysis was ordered. Although the facility's revised R5's care plan to address a UA was conducted, no further interventions were implemented to prevent R5 from future falls. An Incident/Accident Report dated 12/21/15 documents R5 again being found on the floor but by her bed at 4:00 PM. The report documents that R5 had been toileted and put to bed just before being found. Post fall investigations actions included resident teaching and care plan review/revision. Again, etiology on incident undetermined. An Incident/Accident Report documented R5 again being found on the floor between the toilet and her wheelchair in the bathroom on 2/18/16 at 10:45 AM. The report documented R5 stated she lost her balance and fell to the floor. R5 complained of rib pain and was sent to the emergency room with no fractures found. She returned to the facility. The witness statement documented that R5 had been taken to the bathroom and assisted to bed just prior to being found on the floor. R5 was documented as stating she was trying to get up off the toilet and in her wheelchair when the fall occurred. Post fall investigations actions document a referral to therapy and care plan review/revision. Etiology was documented as "fell in her BR (bathroom) self transferring." R5's Care Plan was revised to address that the facility would refer R5 to therapy; however, R5 refused therapy. There was no	F 323		

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further interventions implemented to address this fall or to prevent her from future falls.

On 4/5/16 at 3:30 PM, an Incident/Accident Report documents R5 was observed sitting upright between her wheelchair and the bed in her room. The report documents no injury, etiology unknown and post investigation actions of resident teaching, care plan review/revision and "med reduction." Comments made by R5 according to the report indicated she was trying to put herself to bed.

On 4/7/16 at 5:00 PM, R5 was documented again in an Incident/Accident Report as falling when trying to transfer herself from bed to wheelchair slipping and falling to the floor. The report documented etiology as unknown, implementation of a bed alarm and care plan review/revision.

All the Reports documented above document R5 being alert and oriented with periods of confusion. There is no evidence the facility took into consideration that R5 is cognitively impaired and needed closer supervision. There is no evidence the facility identified that 3 of the 6 falls involved R5 taking her self to/from the toilet and revised the care plan to include a toileting plan. There is no evidence R5 uses her call light and/or can remember her need to call for assistance to use the toilet.

On 4/19/16 at 12:00 PM, R5 was observed in her wheelchair in the dining room with the alarm on her chair. R5 was observed from 9:45 AM on 4/20/16 thru 2:00 PM on 4/20/16 with no toileting offered and/or occurring. R5 was never observed to get up or attempt to get up unattended.

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On 4/22/16 at 3:00 PM, E19, Licensed Practical Nurse (LPN) stated R5 does use the call light at times, has alarm now which goes off occasionally, and sometimes just doesn't want to call for help and attempts self transfers. E19 states R5 often tries to get up unattended especially in her room.

On 4/22/16 at 310 PM, E14, CNA, stated R5 often just doesn't want help and will attempt self transfers.

On 4/26/16, at 9:55 AM, E2 stated that "resident teaching" noted on the incident reports meant that R5 was reminded to use her call light and ask for assistance with toileting.