STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001143	A. BUILDING: _____ B. WING _____	R-C 06/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR PLACE NURSING	6800 WEST JOLIET INDIAN HEAD PARK, IL 60525

(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) COMPLETE DATE
S 000	Initial Comments First Complaint Investigation Certification Revisit to Survey Date 4/16/21 conducted on 6/15/21 Recited F600G & F689G FRI of 3/12/21/IL132096 - F600G FRI of 3/13/21/IL131965 - F689G	S 000		
S9999	Final Observations 1) Statement of Licensure Violations: 300.610a) 300.690a) 300.1210b) 300.1210c)3) 300.1210d)6) 300.3240a) 300.3240f) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.690 Incidents and Accidents	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	S9999		

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S9999	Continued From page 2 seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to follow their abuse policy by not preventing sexual abuse for 2 of 3 residents (R21 and R24) from R16 and also failed to prevent resident to resident physical attacks affecting 3 (R3, R12, and R13) residents all reviewed for	S9999		

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S9999	Continued From page 3 abuse. This failure resulted in R16 inappropriately exposing himself to R21. R21 said she felt angry and scared of R16, this failure also resulted in R16 grabbing and forcefuly tongue kissing R24 on her mouth. R24 said she felt violated by R16's actions. Findings include: R21 was admitted with the diagnosis of Dementia, Lack of Coordination. Brief interview for mental status dated 5/17/21 documents a score of eleven indicates moderate impairment. On 6/4/21 at 2:28pm, R21 who was assessed to be alert to person, place and time, said, R16 was sitting in a chair in my room talking, R16 unzipped his pants, took his penis out and started playing with it. I observed R16 playing with his hands and penis in his lap with white liquid on top his penis. I felt angry, scared and was preparing to defend myself. On 6/9/2021 at 10:14am, V5 (Asst. PRSD) said, R16 exposed himself to R21. On 6/10/21 at 1:07pm, V29 (PRSC) said, R16 has had sexually inappropriate behaviors that was slowly progressing until R16 was discharged to the hospital for exposing self to R21. Physician Progress note dated 5/28/21 documents R21 is alert and oriented time three. Social service note dated 6/2/21 documents: R16 presented with socially inappropriate behavior as evidenced by R16 walking into R21's room and exposing himself. R16 said, that he walked into peer room and began to expose himself to	S9999		

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S9999	Continued From page 4 resident saying he overheard that "resident can have sex for fifteen minutes." Police report dated 6/2/21 documents: R21 was identified as the victim. R21 said R16 exposed himself in her room. Abuse Prevention policy dated 12/19: Resident have a right to be free from abuse. Abuse means any sexual assault inflicted upon a resident other than by accidental means. Sexual Abuse is sexual contact of any type with a resident. R24 was admitted with the diagnosis of schizoaffective disorder and delusional disorder. R24 brief interview for mental status dated 6/2/21 score of twelve which indicated moderate impairment. On 6/10/21 at 2:42pm, R24, who was assessed to be alert to person, place and time, said, "I was assaulted on the elevator in May. I was getting on the elevator, R16 leaned out and hugged and kissed me on the cheek. R16 put his tongue on my cheek and dragged it across my face towards my mouth. I pushed R16 off me before his tongue entered my mouth. I felt violated." On 6/9/21 at 4:45pm and 5:09pm, V1 (administrator) said, R24 was the peer on the elevator with R16. R24 reported that R16 kissed her. R24 said, she felt R16's tongue on her cheek. On 6/11/21 at 12:30pm, V1 (administrator) said, sexual abuse is any unwanted touching, kissing, licking, sexual penetration or sexual advancement. If my staff writes a progress note with the word "attempted" it means my staff saw a	S9999		

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S9999	Continued From page 5 resident trying to do something. Physician note date 5/17/21 documents: R24 is oriented to person, place and time. Social service note date 6/9/21 documents: R24 alleged that peer attempted to kiss her in the elevator. Staff was informed R24 received physical aggression while in the elevator. Abuse Prevention policy dated 12/19: Resident have a right to be free from abuse. Abuse means any sexual assault inflicted upon a resident other than by accidental means. Sexual Abuse is sexual contact of any type with a resident. R16 was admitted on 4/20/21 with the diagnosis of Schizoaffective Disorder, Bipolar, Auditory Hallucinations and Unspecified Psychosis. Brief interview for mental status documents a score of ten which indicated moderate impairment. On 6/8/21 at 5:32pm, R16 who was assessed to be alert to person, place and thing R16 said, I showed my penis to R21. I wanted R21 to s**k it. I touched a resident, who had dark hair and wore glasses, on the breast. On 6/9/2021 at 10:14am, V5 (Asst. PRSD) said, R16 exposed himself to R21. R16 exposed his penis. On 6/10/21 at 1:07pm, V29 (PRSC) said, R16 has had sexually inappropriate behaviors that was slowly progressing until R16 was discharged to the hospital for exposing self to R21. R16 made sexually inappropriate gestures towards staff. On 6/11/21 at 12:30pm, V1 (administrator) said,	S9999		

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the word "noted" is used interchangeable with what the staff observed.

Physician note dated 4/29/21 documents: R16 is oriented to person, place and time. R16 is able to state first and last name, current state located in, as well as what year it is.

Progress note dated 5/18/21 documents: R16 was sexually inappropriate towards a peer in the elevator.

Social service note dated 5/19/21 documents: R16 was noted being sexually inappropriate towards staff while on the elevator. Care plan dated 5/19/21 documents: R16 has been sexually inappropriate towards both staff and residents.

Police report dated 5/27/21 documents: R16 said, he touched a female breast over clothing at the nursing home.

Social service note dated 6/2/21 documents: R16 presented with socially inappropriate behavior as evidenced by R16 walking into R21's room and exposing himself. Petition for involuntary/ judicial admission date 6/2/21 documents: R16 had behavioral concerns as evident by exposing self to peer.

Abuse Prevention policy dated 12/19: Resident have a right to be free from abuse. Abuse means any sexual assault inflicted upon a resident other than by accidental means. Sexual Abuse is sexual contact of any type with a resident.

R3 was admitted to facility on 7/4/2018 with diagnosis of major depressive disorder, chronic kidney disease and cerebrovascular disease. R3 brief interview for mental status dated 5/18/21

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S9999	Continued From page 7 document a score of 14 which indicates cognitively intact. On 5/28/21 at 1:00pm, R3 was alert and oriented at time of interview said that R4 was grabbing things in her room and she asked her to stop. R3 said R4 then smacked her across the face but not hard. R3 reported incident and R3 was moved to different room. R3 said she did not hit R4 back because she is an older lady and has dementia. R3 said R4 has history /behavior of wandering and going through peoples things. Facility abuse reportable dated 5/5/21 documents R3 got upset with R4 because R4 was going through R3's personal belongings. R3 asked R4 to stop, and R4 became physically aggressive towards R3 and struck her with an open hand. After a thorough investigation, there is no credible evidence that abuse occurred based on R4's diagnosis and state of confusion as to whose belongings she was going through. R3's progress notes dated 5/5/21 documents Resident is a 68 year old female. Resident diagnosis is major depressive disorder. Resident BIM score is 14 which can indicate an intact memory. Resident stated peer was upset because resident asked peer to stop going through her personal items. Upon doing this peer then became physically aggressive with resident. Resident and peer were immediately separated. Resident was encouraged to seek staff assistance or your call light before interacting with peers. Resident were immediately separated and a room change was done. R4's progress note dated 5/5/21 documents: Writer was informed that resident was involved in physical altercation. Resident and peer were	S9999		

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immediately separated. Resident was placed on 72-Hour Behavior Monitoring, emotional support and PRN was given. Resident was placed on 1:1 and encouraged to respect peers. Resident was also given time to express concerns in regards to peer and encouraged not to be aggressive towards staff. Resident's peer (R3) was also placed on 72-Hour monitoring. Resident was ensured she lives in a safe place. Resident was encouraged to follow-up with staff immediately when a problem arises.

Facility abuse prevention policy reviewed 1/4/19 documents abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Instances of abuse for all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal, sexual, physical and mental abuse. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual intended to inflict harm or injury.

R12 was admitted to facility on 5/28/19 with a diagnosis of anxiety disorder, bipolar disorder, panic disorder, and post-traumatic stress disorder. R12's brief interview for mental status dated 4/5/21 document a score of 14 which indicates cognitively intact.

On 6/2/21 at 10:19AM, R12 who was alert and oriented at time of interview, said R4 hit her in the head with top of food covering from the tray 4 times. R12 said she had a little mark but was ok.

Facility reportable dated 4/25/21 documents: R12 reported that R4 threw a breakfast tray towards

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her and food got on R12, but the tray did not touch her. After a thorough investigation, there is no credible evidence that abuse occurred based on R4 being confused related to her diagnosis of dementia and Alzheimer's disease.

R12's progress notes dated 4/25/21 document: During medication pass writer heard yelling coming resident room. Resident informed writer that her roommate threw her breakfast tray on her. Writer asked what happened? Resident stated she threw her breakfast tray on me for no reason. Resident was immediately separated. Head to toe assessment done. No c/o pain/discomfort noted.

R4's progress note dated 4/25/21 documents: It was reported to the writer that the resident was in a physical altercation with her roommate. The peer stated the resident had poop in her hands. The peer asked her if she could wash. The resident grabbed the tray and hit her with it four times until she stopped. The writer conducted 1:1 counseling with the resident to vent feelings and concerns. The writer encouraged the resident to maintain boundaries with peers. The writer encouraged the resident to seek staff assistance when situations arise.

Facility abuse prevention policy reviewed 1/4/19 documents abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Instances of abuse for all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal, sexual, physical and mental abuse. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual intended to

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S9999	Continued From page 10 inflict harm or injury. R13 was admitted to facility on 5/22/2018 with diagnosis of psychotic disorder with delusions, schizoaffective disorder, major depressive disorder and anxiety disorder. R12's brief interview for mental status dated 5/12/21 document a score of 12 which indicates moderately impaired. Facility abuse reportable dated 2/11/21 documents: R4 was sitting on R13's bed while R13 was sleeping. R4 was confused and thought that R13 was in R4's bed. R13 told R4 to get off her bed. R4 became upset and hit R13. After a thorough investigation, there is no credible evidence that abuse occurred due to R4 low BIMS (brief interview for mental status) score of 0 and confusion which is related to Alzheimer's disease. On 6/2/21 at 12:15PM, R13 who was alert and oriented at time of interview, said R4 attacked her with the top of the toilet lid. R4 was holding toilet lid cover over her face and hit her with it. Staff came and were able to remove R4. R4 changed rooms. R13's social service progress note documents dated 2/11/21: Resident is a 34 year old female who is alert and oriented X3. Resident is able to communicate wants and needs with clear speech. Resident has a diagnosis of schizoaffective disorder, major depressive disorder, attention deficit hyperactivity disorder, and anxiety disorder. Resident ambulates independently and is able to perform ADL's independently. Resident is compliant with meals, medications, and ADL's. It was reported to the	S9999		

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S9999	Continued From page 11 writer by nurse that this resident received physical aggression from peer while in her room. Writer immediately investigated event. Upon investigation, resident stated that peer hit her with toilet lid then choked her by grabbing her jacket hood. Writer immediately did 1:1 counseling with resident to vent feelings and concerns. Writer did breathing techniques with the resident. Writer also gave resident a leisure packet to help calm and redirect her. Writer encouraged resident to maintain boundaries with peer. Writer re-educated resident on COVID-19 policy. Writer encouraged resident to seek staff before situations arise. R4's progress note dated 2/11/21 documents: It was reported to the writer from the 2nd floor nurse that this resident initiated physical aggression on peer on the 2nd floor in the room. Resident were immediately separated. Writer investigated immediately. Upon investigation, it was reported that resident was sitting on peer's bed. Peer asked resident to leave because she was still trying to sleep. Resident then became agitated and grabbed the toilet seat and attempted to strike peer. Writer attempted to conduct 1:1 counseling with resident. Resident was calm due to not remembering. Resident stated "I did not fight with anyone, I have been eating breakfast all morning". Writer encouraged resident to refrain from all forms of aggression. Writer encouraged resident to seek staff assistance as needed. Resident will be petitioned out to local hospital. R4's note does not indicate any hospitalization. Facility unable to provide petition when requested. Facility abuse prevention policy reviewed 1/4/19 documents abuse as the willful infliction of injury,	S9999		

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S9999	Continued From page 12 unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Instances of abuse for all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal, sexual, physical and mental abuse. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual intended to inflict harm or injury. (A) 2) Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)3) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.	S9999		

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S9999	Continued From page 13 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision	S9999		

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S9999	Continued From page 14 and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to 1) implement effective interventions of wearing a helmet to reduce the injury during potential fall incidents for a resident with a diagnosis of Huntington disease this affects 1 resident (R2) reviewed for fall risk interventions The facility also failed to 2) supervise a resident with a history of wandering and having peer to peer altercations for 1 (R4) resident reviewed for supervision. The facility's failure resulted in R2 having multiple falls and being transported to the local hospital and treated for head injuries to include lacerations requiring sutures. Findings include: 1) R2 admitted to the facility on 8/19/12 with a diagnosis of Huntington's disease, hyperlipidemia, hypothyroidism and dysphagia. R2 minimum data set (MDS) dated 2/23/21 documents a brief interview for mental status score of 0 which indicates cognitively impaired. Under section G documents one person physical assist with transfers, walk in room, walk in corridor, locomotion on and off unit.	S9999		

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S9999	Continued From page 15 During the survey, R2 was observed wearing a black helmet. The helmet was noted to cover her entire head and forehead. R2's fall report dated 4/4/21 documents R2 fell backwards to the floor near her wheelchair. Abrasion on the back of her head. Under injury documents abrasion on top of scalp R2's fall risk review dated 4/4/21 documents a score of 12 high fall risk due to balance problem when walking; Exhibits loss of balance while standing; Changes gait pattern when walking through doorways; Exhibits jerking or instability when making turns; Uses an assistive device, e.g. cane, walker, wheelchair, etc; Decrease in muscle coordination. R2's progress note dated 4/6/21 documents: writer was called by the CNA. R2 was sitting on the floor with blood on the floor. Writer cleaned the wound on resident's top of the head with saline. Packed it with gauze and placed a bandage. On 6/2/21 at 3:52PM, V23 (Nurse) said she asked V8 (CNA) to help R2 back to her wheelchair because she was ambulating in front of nursing station. V8 assisted R2 back to her wheelchair and assisted her back to her room. V8 reported that he was leaving the room to get supplies when it was thought that R2 stood up from wheelchair and then went to sit back down. When R2 went to sit back down, the wheelchair moved back and R2 hit her head on the arm of wheelchair and sat on her buttocks. V23 said the wheelchair was not locked for it to move back and reported R2 was not wearing her helmet. V23 did not receive any report of R2 refusing to wear helmet.	S9999		

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S9999	Continued From page 16 On 6/1/21 at 10:3PM, V8 (CNA) said he did not see R2 fall on 4/6/21. V8 said he was assisting R2 with care and left the room to get supplies when he entered the room, R2 was sitting on the floor and the wheelchair was behind her. V8 said the wheelchair was not locked and R2 was not wearing helmet at time of incident. V8 was unaware that R2 had a helmet. R2's facility reportable dated 4/6/21 documents: Resident was observed siting on the floor. Noted with laceration on top of her head. R2 was observed with wheelchair at her back. R2 sent to local hospital and returned with 2 staples to head. R2 tends to be impulsive and became agitated with redirection attempts. R2 will plunk herself into her wheelchair. It was concluded that the root cause of the fall is that she missed her wheelchair when attempting to sit and fell. Interventions facility will conduct medication review. Care plan and assessments updated as indicated. Incident report on 4/6/21 at 6:50PM that R2 was sitting on the floor with blood on the floor. R2's hospital record dated 4/6/21 documents R2 was found on the floor by her wheelchair. Staff believes R2 possibly fell back out of her wheelchair and hit her head. R2 sustained a small laceration to her posterior (back) scalp. Two staples were placed. R2's progress note dated 4/10/21 documents: Peer informed writer that resident was ambulating without assistance, and fell face forward in the hallway. Head to toe assessment done. Writer observed resident has a laceration on the left side of the forehead, and a laceration on the back of head. Administrator made aware.	S9999		

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S9999	Continued From page 17 R2's facility reportable dated 4/10/21 documents: R2 suddenly stood up, lost her balance and fell forward. R2 sent to local emergency room and came back same day with sutures to her forehead. It was concluded the root cause of her losing balance is due to her involuntary movement secondary to her Huntington's disease. Interventions resident directed to get up slowly from the wheelchair. Incident report dated 4/10/21 documents: Peer informed writer that resident was ambulating without assistance and fell face forward in the hallway. Laceration on the left side of forehead and laceration on the back of head On 6/1/21 at 1:46pm, V9 (nurse) said staff reported on 4/10/21, R2 was walking down hallway unassisted, before staff could intervene R2 fell face forward and hit her head on floor. R2 did not have a helmet on at time of incident. R2 sustained a injury to the forehead. V9 unable to explain how R2 sustained injury to back of head or if R2 fell again same day prior to transfer to hospital. R2's hospital record dated 4/10/21 documents R2 from facility for witnessed fall. R2 hit wall and fell backwards. R2 has wound to her forehead and previous staples to back of her head now bleeding. There is a 3cm laceration extending from the previous 3 cm laceration that is stapled on the septal area. There is a 3cm wide laceration on her left mid forehead. Three sutures were placed on forehead and 3 staples were placed on scalp. Computerized tomography of the head dated 4/10/21 documents small scalp hematoma and laceration with skin staples overlying high left parietal calvarium. Scalp	S9999		

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S9999	Continued From page 18 laceration with small hematoma overlying the left frontal calvarium, (front of skull). On 6/10/21 at 10:39AM, V1 (Administrator) said R2 will refuse to wear her helmet. The helmet is used to protect her head from injury. V1 said she would expect staff to continue to offer R2 helmet, inform social services of refusal and staff should document all attempts or refusal. V1 said she did not assist with fall reportables on 4/6/21 and 4/10/21. V1 said unsure if R2 was wearing helmet at time of fall from the reports. On 6/11/21 at 10:05 am, V38(Former DON) said she thought R2 was wearing her helmet at the time of the falls but was unable to explain why that intervention was not documented in any of the reports or investigations. When asked how R2 sustained injuries to her head if helmet was on, V38 responded that maybe the helmet fell off when she fell or was not secured properly. R2's April progress notes do not document any refusals of the helmet. R2's fall report dated 3/15/21 documents: R2 fell on the floor trying to transfer to weight scale. R2's fall report dated 3/23/21 documents: R2 was observed on the floor in common washroom. No witnesses found. And checked not using wheelchair. R2's fall report dated 4/12/21 document R2 was sitting in front of nursing station and tried to stand up and lost her balance and fell to floor. No witness found. R2's progress note dated 5/19/21 documents; R2 sitting in the hallway outside the dining room. R2	S9999		

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S9999	Continued From page 19 with superficial cut on inside lower lip. R2's care plan documents: R2 is at risk for falls related to Huntington's disease, hyperlipidemia, hypothyroidism, feeding difficulties, dysphagia R2 was offered a helmet for her head and she refused to wear it. She was educated on the importance of wearing the helmet. R2 will sit in chair with legs crossed and was educated not to sit that way due to fall risk. R2 has impulsive behaviors and gets out her chair. Date Initiated: 11/18/2019 with revision on: 02/22/2021. Following interventions were documented: Psychiatrist- MD consult for medication review. Date Initiated: 04/06/2021; chair needs to be place against the wall for stability and the resident's name placed on it. Date Initiated: 01/29/2020 and revision on: 01/20/2021; CNAs/Nurses to provide contact guard when transferring from one surface to another and during weighing on standing scale. Date Initiated: 03/17/2021 with revision on: 04/08/2021; Commode placed over toilet/grab bars on toilet to make standing up easier. Date Initiated: 08/19/2019; Non-slip pad placed in seat of Resident's wheelchair, to prevent sliding. Date Initiated: 08/19/2019; R2 have impulses behavior; Nurses utilize PRN psychotropic per MD order. Date Initiated: 11/05/2020 and revision on: 03/24/2021; Low bed. Date Initiated: 11/18/2019 and revision on: 01/20/2021; MD notified new order for UA C&S (urine specimen). R2 to be encouraged to sit in wheelchair. Date Initiated: 04/05/2021; medication review and neuro checks. Date Initiated: 02/27/2021; monitor for orthostatic hypotension. Date Initiated: 08/19/2019; Neurology consult to be scheduled. Date Initiated: 04/12/2021; New wheelchair cushion and antilock brakes to wheelchair. Date Initiated: 01/19/2021 and Revision on: 04/08/2021; new shoes	S9999		

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provided. Date Initiated: 08/23/2020; new shoes without laces provided. Date Initiated: 09/03/2020; noncompliant with staying in wheelchair. Date Initiated: 11/05/2020; observe frequently and placed in supervised area when out of bed. Date Initiated: 08/19/2019; Offered helmet for head Resident refused. Date Initiated: 09/27/2019; Physical Therapy to evaluate and treat for strengthening and balance. Date Initiated: 08/19/2019. Proper fitting pants provided. Date Initiated: 12/01/2020. Revision on: 04/08/2021. Re-educated resident on fall precautions, need for safety helmet to be worn while out of bed. Date Initiated: 12/04/2019; Resident encouraged to walk with assistance however declines. Date Initiated: 02/10/2020. Resident provided helmet and refused to use it. Date Initiated: 02/10/2020. Resident to be in close area for monitoring to prevent falls. Date Initiated: 11/04/2020. Resident to keep proper foot ware on at all times. Date Initiated: 02/10/2020. Resident to wear appropriate footwear. Date Initiated: 02/17/2020. Resident to wear helmet & hip protectors. Date Initiated: 02/17/2020. Revision on: 01/20/2021. Staff educated on fall prevention efforts and strategies. Date Initiated: 08/19/2019. Staff to assist resident by holding chair to prevent tipping when she is attempting to sit. Date Initiated: 09/28/2019. Staff to monitor assist as needed when attempting to sit in chair. Date Initiated: 09/20/2019. Staff to remind resident to not sit in chair with legs crossed. Date Initiated: 11/22/2019. Stationary chair removed from bedside. Date Initiated: 03/21/2020. Revision on: 01/20/2021. Therapy to screen. Date Initiated: 02/17/2020. Toilet program. Date Initiated: 03/25/2021. R2 encouraged to wait for staff prompts while toileting. Date Initiated: 09/04/2020. R2 provided proper fitting pants to prevent pant leg from sagging under her feet

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S9999	Continued From page 21 causing her to fall. Date Initiated: 08/23/2020; R2 was sent to ER for further evaluation due to laceration to the back of her head after first aid provided. Date Initiated: 04/06/2021. Transferred to hospital. Date Initiated: 12/30/2019; Wheelchair provided for locomotion. Date Initiated: 09/28/2020. Gather information on past falls and attempt to determine the root cause of the fall(s). Anticipate and intervene to prevent recurrence. Date Initiated: 08/19/2019. Be sure call light is within reach and encourage the resident to use it for assistance as needed. Staff to respond promptly to all requests for assistance. Date Initiated: 08/19/2019. Anticipate and meet individual needs of the resident. Date Initiated: 08/19/2019. Complete the Fall Risk Review per the facility protocol. Date Initiated: 08/19/2019. Facility provided brand of helmet R2's wears which is a soft padded helmet which protects against cuts and abrasions. (B)	S9999		