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	IL6012322	A. BUILDING: _____ B. WING _____	09/29/2022

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MOWEAQUA REHAB & HCC	525 SOUTH MACON STREET MOWEAQUA, IL 62550

(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 Annual Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)2) 300.1210 d)3) 300.1210 d)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These regulations are not met as evidenced by: Based on observation, interview, and record review, the facility failed to prevent the development and worsening of pressure ulcers by failing to: ensure a residents brace was in proper position and monitored, monitor skin condition underneath a brace, implement turning and	S9999		

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S9999	Continued From page 2	S9999		

positioning programs, assess a pressure ulcer upon admission, provide pressure ulcer treatments and interventions, and routinely assess, monitor, and provide pressure relieving interventions for residents. These failures affect four (R33, R26, R246, R27) of five residents reviewed for pressure ulcer on the sample list of 37. This failure resulted in R33 developing an unstageable pressure ulcer to the right lower leg exposing muscle and ligaments, a unstageable pressure ulcer to the heel, and three stage two pressure ulcers to the right, left hip, and sacrum, and resulting in R26 developing an unstageable pressure ulcer to the sacrum.

Findings include:

1. R33's Admission assessment, dated 8/12/22 at 12:31 PM, documents R33 does not have pressure ulcers, and is at mild risk for pressure ulcer.

R33's Nurse's note, dated 8/12/2022 at 2:44 PM, documents R33 has a black immobilizer to the right leg that R33 is to wear at all times.

R33's medical record does not include an order for the brace, the position in which the brace should be placed, monitoring of the brace's position, or monitoring the skin under the brace.

R33's Pressure Ulcer Risk Assessment, dated 8/19/22 with a lock date of 9/8/22, documents R33 is a moderate risk for pressure ulcers.

R33's Admission Minimum Data Set assessment, dated 8/25/22, documents R33 is totally dependent with two person assist for turning and positioning.

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S9999	Continued From page 3	S9999		

R33's Skin/Wound Note dated 8/27/2022 at 11:11 AM documents, "New pressure wound noted to inner (right) ankle. (10.5 centimeter (cm) X 4 cm). Severe pain to the area. Foul odor noted (with) moderate drainage. Wound was noted after removing the leg brace off her lower R leg/ Indentation from the brace noted to the R (right) ankle. Although, brace is to be on her Upper thigh for the healing femur (fracture). Also, eschar noted to R heel."

R33's Skin and Wound Evaluation, dated 9/20/22, documents a new, in house acquired open lesion to the left buttock measuring 2.9 cm by 2.7 cm by 1.6 cm wound.

R33's Skin and Wound Evaluation, dated 9/20/22, documents a new, in house acquired open lesion to the right buttock measuring 2.8 cm by 2.1 cm by 1.8 cm wound.

R33's Skin and Wound Evaluation, dated 9/20/22, documents Moisture Associated Skin Damage to the Sacrum measuring 10.5 cm by 6.1 cm by 2.8 cm.

On 9/27/22 at 1:38 PM, V21, Registered Nurse, and V3, Licensed Practical Nurse/Wound Nurse, changed the dressing to R33's wounds. The wound to R33's right lower leg was 8 centimeters (cm) by 3.5 cm with a depth of 0.9 cm. The wound was 90 percent covered with dark yellow gray slough. The outer edge of the wound exposed muscle and ligaments. There was a unstageable pressure ulcer to R33's right heel that measured 1.1 cm by 1.9 cm. This wound was covered with black eschar. There was a stage two circular pressure ulcer to the sacrum measuring 1.2 cm in diameter. There was scarring to R33's left and right buttocks. V3

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S9999	Continued From page 4	S9999		

stated these areas were healed facility acquired stage two pressure ulcers.

On 9/27/22 at 9:45 AM, V17, Licensed Practical Nurse (LPN), stated when she assessed the area, she noticed that the "brace was in the wrong spot; it was supposed to be on the upper leg. The brace was an immobilizer and was supposed to be positioned so the she could not bend at the knee. It should not have been positioned as low as it was. The (unknown) Certified Nurse's Assistants came and got me because they noticed blood on her leg around her ankle." V17 stated she ended up taking it off because she didn't have an order for the brace. V17 stated it was the first time she had taken care of her, and she usually has a different hall. V17 stated the wound to the inner ankle had a lot of drainage, and she could tell it was caused from pressure, because there was an indentation where the brace was sitting. V17 stated, "It was an irregular shaped ulcer with an indentation and that the wound bed was green." V17 stated her right heel was also black.

Review of R33's medical record does not document R33 was on a turning and positioning program or that R33 received turning or positioning.

On 9/28/22 at 12:56 PM, V22 (Physician's Nurse) stated V9 (R33's physician) would have expected an order for R33's Brace including the placement of the brace, monitoring the position of the brace, and monitoring the skin under the brace. V22 stated V9 would have expected a turning and positioning program to be implemented to prevent the development of pressure ulcers

On 9/26/22 at 4:02 PM, V2 Director of Nursing

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S9999	Continued From page 5 confirmed a turning and positioning program was not implemented for R33. V2 confirmed R33's medical record did not document the receipt of turning and positioning. V2 also confirmed R33's medical record did not contain an order for the brace, the position in which the brace should be placed, monitoring of the brace's position, or monitoring the skin under the brace. The facility's pressure ulcer pressure injury prevention policy, dated 4/2018, documents for residents at moderate risk for pressure ulcer the facility will implement, "Individualized turning and repositioning (utilizing a 30-degree rule)." 2. R26's medical record documents R26 was admitted to facility on 7/24/22, with diagnoses of Coronary Artery Disease, Diabetes, Hypertension, Spinal Stenosis and Congestive Heart Failure. R26's Hospital discharge instructions, dated 7/24/22, documents, "Wound care per facility protocol." R26's Admission Skin Integrity assessment, dated 7/24/22, documents, "Open area to lower back". No measurements or a wound description is documented. R26's Nurses Notes documented on 7/24/22, by V18, Licensed Practical Nurse, "Resident has an open area on lower back." V18 LPN stated, "On 7/24/22, (R26) admitted with a stage 2, open area to the sacrum, there was no drainage to the wound, the wound bed was pink, there was no slough or eschar to the wound. I don't know exact measurements, it was bigger than a dime but smaller than a quarter."	S9999		

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S9999	Continued From page 6 R26's Braden skin risk assessment, dated 7/24/22, documents a score of "16", indicating "at risk" for skin breakdown. R26's medical record does not document a physician ordered treatment to R26's open area to lower back from admission date of 7/24/22 through hospital admission date of 8/4/22. R26's medical record documents on 8/4/22, R26 was sent to the emergency room and admitted to the hospital with a diagnosis: Septic Shock. R26's hospital records document, "Hospitalist Admission History and Physical, date of service: 8/4/22, Physical Exam: Stage two thoracic pressure ulcer. R26's Hospital Wound Clinic Consult notes, signed by V23 (Hospital Wound Nurse) documents, "Wound 8-5-22 Sacrum open, black wound bed, Unstageable." Wound on 8-11-22, wound bed: full thickness, eschar full coverage, brown, black fragile red, wound length: 1.6 centimeters, wound width: 3.6 centimeters, wound depth: 0.2 centimeters, wound surface area: 5.76 centimeters squared." R26 readmitted back to the facility on 8/17/22. R26's hospital discharge orders dated 8/17/22, "Wound care instructions: Wound care: cleanse sacral wound with normal saline and pat dry edges apply Santyl nickel thickness to necrotic wound bed pack with saline moistened gauze cover with Aquacel (foam dressing), change twice a day and as needed." R26's Readmission skin integrity assessment, dated 8/17/22, documents, "skin integrity: does resident have impaired skin integrity: yes, Resident was readmitted with the following skin	S9999		

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S9999	Continued From page 7 issues: assessment is blank." R26's medical record does not document a description, type of wound or wound measurements for R26's sacral wound from readmission date of 8/17/22 through 8/22/22. R26's medical record does not document the hospital wound care instructions, dated 8/17/22, were implemented by the facility until 8/22/22. R26's Physician order summary documents, "Cleanse sacral wound with normal saline, pat dry, apply Santyl (enzymatic debrider) to necrotic wound bed and pack with saline moistened gauze, cover with Aquacel (foam dressing), two times a day for Wound care, start date: 8/22/2022, end date: 9/9/2022." R26's Skin Wound Evaluation form, completed by V2, Director of Nursing, dated 8/22/22, documents, "Pressure, Unstageable, Slough/Eschar, location: is blank, acquired: present on admission, how long present: Unknown, Wound Measurements: (surface area: 6.72 centimeters squared), wound length: 3.2 centimeters, width: 2.1 centimeters, depth: not applicable. Treatment- dressing appearance: "Missing" is checked. Notes: readmitted to facility on 8/17/22 from hospital with sacral wound. Treatment orders in place. Wound care to see on next visit." R26's Skin Wound Evaluation form, dated 9/2/22, documents, "Pressure, Unstageable, Location: is blank, Wound measurements: blank, slough, increased drainage." No notes, no measurements documented. R26's Skin Wound Evaluation form, dated 9/7/22,	S9999		

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S9999	Continued From page 8 documents, "Pressure, Unstageable, Location: is blank, Wound measurements: 4.5-centimeter length, 1.9 cm width by 2.9 cm depth. (Surface area: 8.55 cm2.) " R26's Skin Wound evaluation form, dated 9/13/22 documents, "Pressure, Unstageable, Location: is blank, Wound measurements: 4.9 centimeters length, 1.5 centimeter width, depth: not applicable. (Surface area: 9.31 cm2)." R26's Skin Wound Evaluation, form dated 9/20/22, documents, "Pressure, Unstageable, Location: is blank, Wound measurements: 4.1 centimeters length, 2.3 centimeters width, depth: not applicable. (Surface area: 9.43 cm2)." R26's Physician orders summary documents, "Cleanse sacral wound with Generic Wound Cleanser, apply Santyl and Calcium Alginate and cover with Silicone bordered foam. May substitute Promogran Prisma if out of Calcium Alginate. two times a day for Wound care, start date: 9/9/2022 end date: 9/16/2022." R26's Physician order summary documents, "Cleanse sacral wound with Generic Wound Cleanser, apply Santyl and Calcium Alginate and cover with Silicone bordered foam. May substitute Promogran Prisma if out of Calcium Alginate, two times a day for Wound care, start date: 9/17/2022." R26's Treatment Administration Records (TAR) do not document the completion of physician ordered treatment to R26's sacral wound: at 8:00 AM on 8/26/22, 8/27/22, 8/28/22, 8/30/22, 8/31/22, 9/3/22, 9/4/22, 9/6/22, 9/10/22, 9/11/22, 9/14/22, at 7:00 PM on 8/23/22, 8/25/22, 8/26/22, 9/1/22, 9/3/22, 9/4/22, 9/7/22, 9/12/22, 9/13/22,	S9999		

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S9999	Continued From page 9 9/15/22, or at 1:00 AM on 9/23/22 and 1:00 PM on 9/18/22, 9/19/22, 9/20/22, 9/24/22 and 9/25/22. On 09/26/22 at 11:29 AM, R26 states, "Sometimes they do the treatment once a day and sometimes it is twice a day, just depends on if they have time or not." R26's Minimum Data Set assessment, dated 8/24/22, documents R26 as cognitively intact. On 9/27/22 at 2:15 PM, V2, DON, stated, "The nurse that does the admission on hallway is responsible to assess and measure wounds. Normally, if a resident admits with a wound, they have Physician orders, if not we have a protocol the nurse can follow and call and get physician orders. If the staff do not feel comfortable they can notify (V3 Wound Nurse) and (V3) will do the assessment and obtain and write orders. Wounds should be measured weekly and the description documented. Nurses are to sign out treatments on the TARs after they are completed, if a resident refuses it is to be documented on the TAR's, if it is blank that can mean they forgot to sign it out or they did not do it." Wound care observations were completed on 9/27/22 at 3:02 PM with V21, Registered Nurse, and V3, Wound Nurse. V3 measured R26's sacral wound, R26's wound depth was: 0.7 cm, width was 3.4 cm and length was 3.4 cm (wound surface area: 11.56 cm2), V3 stated, "the wound is unstageable. no undermining, no tunneling is present." R26's wound bed appeared red with minimal scattered spots of slough present. On 9/28/22 at 10:10 AM, V22 (Physician's nurse) stated, "(V9, R26's Physician) expects the facility to assess a residents wound on admission,	S9999		

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S9999	Continued From page 10	S9999		

contact the physician or wound care provider in house for a treatment order, apply the physician ordered treatment, and monitor the wounds weekly."

On 9/28/22 at 3:00 PM, V3, Wound Nurse, confirmed there was no assessment, measurement, or treatment for R26's sacral wound from 7/24/22 through 8/4/22. V3 also confirmed no assessment was completed for R26's sacral wound after readmission from hospital on 8/17/22 until 8/22/22, and a treatment was not initiated to R26's sacral wound ulcer until 8/22/22. V3 confirmed R26's TAR's do not document the completion of R26's physician ordered treatment twice a day as ordered.

3. R246's medical record documents an admission date of 9-16-22.

R246's Admission Skin Integrity assessment, dated 9-16-22, documents a Stage 1 pressure ulcer to sacrum (Admitted with) and a Stage 2 pressure ulcer to ischium (admitted with). No measurements or wound description is documented on this assessment.

R246's physician order summary documents the following: "(hydrocolloid dressing) Apply to Ischium topically every night shift every 3 days for Wound healing, start date 9/16/22 and (hydrocolloid dressing) Apply to sacrum topically every night shift every 3 days for wound healing, start date: 9/16/2022."

R246's progress notes, dated 9/16/22, document "Has one (hydrocolloid dressing) covering coccyx area." (no measurements or wound description is documented).

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S9999	Continued From page 11 R246's Pressure Ulcer Risk Assessment, dated 9/16,22 score of 10, indicating "at high risk" for skin breakdown. R246's Careplan, initiated on 9/19/22, documents, "(R246) has potential/actual impairment to skin integrity related to stage I pressure ulcer to sacrum ad stage II pressure ulcer to ischium. Evaluate wound for: Size, Depth, Margins: peri-wound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis. Notify physician as indicated." R246's medical record does not document the measurements or a wound assessment for R246's wounds from admission on 9/16/22 through 9/28/22. On 9/28/22 at 12:45 PM, V3, Wound Nurse, confirmed R246 did not have measurements or wound description documented in R246's medical record. 4) R27's Care Plan (8/19/2022) documents R27 has impaired skin integrity and a coccyx wound. The same record documents staff are to keep R27 off of R27's back while in bed and to respond immediately to any complaints of pain. R27's diagnoses sheet (9/28/2022) documents the diagnosis of Stage 4 Pressure Ulcer. R27's Minimum Data Set (8/7/2022) documents R27 is at risk for developing pressure ulcers/injuries and has one or more unhealed pressure ulcers. On 9/25/2022 at 11:11 AM, R27 was laying on	S9999		

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S9999	Continued From page 12 R27's back in bed on top of a mechanical lift sling, and reported having pain on R27's left back area. R27 reported telling staff thirty minutes ago about having pain, and they replied they would come back in five minutes to help R27, but R27 reported nobody returned to R27's room. V28 (Certified Nurse Aide) was present in the hallway outside of R27's room, and reported R27 had a wrinkle in the fabric mechanical lift sling he was laying on, and V28 was not going to fix the wrinkle for R27 until R27 was transferred from the bed for lunch, which was not until 12:00 PM. (A) 2 of 2 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.	S9999		

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	IL6012322	A. BUILDING: _____ B. WING _____	09/29/2022

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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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 and assistance to prevent accidents. These regulations are not met as evidenced by: Based on observation, interview, and record review, the facility failed to prevent falls by failing to provide supervision; failing to ensure a safe room environment; and failing to maintain wheelchair brakes in working condition for three (R197, R10, R20) of five residents reviewed for falls on the sample list of 37. This failure caused R197 to fall sustaining a laceration to his left eye brow which required medical intervention to close.	S9999		

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S9999	Continued From page 14 Findings Include: 1. R197's admission record, printed 9/29/22, lists the following diagnoses: Dementia with Behavioral Disturbance, Type II Diabetes with Neuropathy, Cognitive Communication Deficit, Muscle Weakness, Unsteadiness on Feet, Chronic Kidney Disease, Altered Mental Status, and Parkinson's Disease. R197's Minimum Data Set (MDS), dated 8/24/22, documents R197 is severely cognitively impaired, experiences hallucinations and Delusions, displays physical, verbal, and other behavioral symptoms directed at others, and wanders. R197's Care Plan, reviewed 9/20/22, documents "(R197) is at risk for falls (related to) Deconditioning. (R197) will be free of falls through the review date. Call Don't Fall" sign. Assess clothing for proper fit. Be sure (R197) call light is within reach and encourage (R197) to use it. Encourage (R197) to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Ensure personal items are within reach." R197's progress note, dated 9/24/2022 at 4:15 PM, documents, " (R197) was wandering in the hallways and staff found him exiting through the Assisted Living Facility doorway. CNA (Certified Nurse's Assistant) noticed his face was bleeding and he stated he had stubbed his toe and fell to the floor hitting his head and left side of his face. Writer administered first aid, started neurochecks, vital signs, and evaluated his range of motion. (R197) was sent to emergency room for evaluation."	S9999		

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S9999	Continued From page 15 R197's Progress note, dated 9/24/22 at 8:22 PM, documents, "(hospital) called to report (R197's) CT (computerized tomography) scan was negative and the laceration to his eyebrow was (closed with wound adhesive). He is ready to return to facility." On 9/25/22 at 11:11 AM, (R197) was laying across unoccupied bed in his room feet on the floor and his upper body across bed. R197 had a laceration approximately 3 inches long above his left eye brow. Transparent wound adhesive is visible on the laceration. There was also a purple bruise surrounding R197's eye. R197 was struggling to upright himself. There were no staff visible in room or surrounding corridor. When asked if (R197) is able to get back up, (R197) mumbled and shook his head to indicate he was not. As R197 struggled, he moved his upper body closer to the edge of the bed. On 9/26/22 at 2:20 PM, V26, Certified Nursing Assistant, (CNA) stated, "I was working (9/24/22) when (R197) fell. (R197) wanders a lot and tries to get out the door. He thinks he's going home. The kitchen is close to the double doors into the assisted living area. The doors are alarmed, but the kitchen staff help out by putting in the code and turning off the alarms when they sound because people like maintenance staff go in and out that door a lot. Another staff (V32, Certified Nursing Assistant) came to the nurse's station to find the nurse. She said she found (R197) all the way through the double doors into the assisted living area and he was bloody. I went up to the hall by the kitchen and found bloody foot prints in the hall and (R197) was on the floor in the front hall of assisted living. The nurse came and we got (R197) back to his room. The nurse called the ambulance and (R197) went to the emergency	S9999		

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S9999	Continued From page 16 room." The facility's Fall investigation report does not include the witness as described by V26. On 9/26/22 at 3:00 PM, V1, Administrator, stated, "That was (V32, Certified Nursing Assistant)." V1 provided a copy of a hand written statement by (V32). The statement documents, "I (V32) heard the alarm go off at the assisted living area and I saw (R197) walking and bleeding. I did not witness the fall." V32 could not be reached for interview. On 9/27/22 at 11:00 AM, V2, Director of Nursing, stated, "(R197) does wander a lot. He should not have made it all the way over to Assisted Living. We have a lot of challenges when it comes to staffing. The kitchen staff should not be shutting off the door alarms unless they check why it is alarming." 2. On 9/25/22 at 9:11 AM, R10 stated, "I tripped over a (mechanical lift) leg, the staff left in the room a couple weeks ago, my hip is sore from it. I am able to walk around with my cane." R10's medical record documents on 9/9/2022 at 10:53 AM, "Resident stated that (R10) was moving the machine out of her room (mechanical lift) and tripped over it as (R10) was pushing it out of the door way. An area of redness was noted to resident's left deltoid area from when she slid through the doorway and bumped arm on the doorway as she fell. Resident landed on left side of buttocks before laying back to her left side." The facility's Fall Details report documents, "R10, type: fall, location: residents room, witness: V7 LPN, Environmental conditions: Obstacles in path- (Mechanical Lift). Conclusion: resident was	S9999		

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S9999	Continued From page 17 going into her room after breakfast and moved the lift out of the way and tripped over it. Education completed with staff to move equipment out of room when care is completed. On 9/26/22 at 9:36 AM, V2, Director Of Nursing, stated, "The (mechanical lift) had been used by staff for (R10's) roommate, staff had left it in the room, R10 tripped over it." On 9/28/22 at 11:40 AM, V7, Licensed Practical Nurse, stated, "I was on the hallway passing medications and I saw the (mechanical lift) come out or R10's room and then R10 fall out the doorway beside the (mechanical lift). Staff had left the mechanical lift in (R10's) room, (R10) stated (R10) was trying to push the mechanical lift out of (R10's) room. (R10) had redness to her left arm that later turned into a bruise. I educated staff to not keep medical equipment in resident rooms." 3. On 9/25/2022 at 10:30 AM, R20 reported R20's right wheelchair brake does not work; it will not effectively engage. R20's right wheelchair brake was observed immediately disengaging after any force was applied to R20's wheelchair. R20's wheelchair was unable to remain in a stationary position with the dysfunctional right brake. R20 reported telling facility staff several days ago about the failed wheelchair brake, but no staff had yet responded to R20. R20 reported requiring the use of a mechanical lift for transferring from R20's bed to R20's wheelchair, and using the wheelchair brakes engaged during those transfers, and also while seated at the dining room table. On 9/28/2022 at 11:10 AM, R20 was seated in the above wheelchair, and again reported telling	S9999		

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S9999	Continued From page 18 maintenance about five days ago about R20's right wheelchair brake not working, but maintenance staff have not fixed the brake yet. R20 reported direct care staff sometimes complain about the non-functioning wheelchair brake when transferring R20 to R20's wheelchair. R20 then demonstrated the right brake not being able to remain engaged. R20 reported liking to have the brakes engages while at the dining room table to keep from rolling backwards. Resident Council minutes (5/6/2022) documents, "(R20) needs (R20's) brakes fixed on her chair". The same record documents on 9/6/2022, "(R20) needs wheelchair fixed." The facility's Fall Prevention Policy, revised 2021, states, "Following any falls the facility completes an occurrence report. Details of the fall will be reported and potential casual factors identified and investigated. Interventions will be immediately implemented following each fall and added to the resident's plan of care." (B)	S9999		