STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005870	A. BUILDING: _____ B. WING _____	C 04/22/2022

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HELIA HEALTHCARE OF ENERGY	210 EAST COLLEGE ENERGY, IL 62933

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S 000	Initial Comments Complaint Investigation #2252832/IL145655	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 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. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to ensure necessary reporting of a fall was completed in order to immediately assess for resident injury and evaluate potential causal factors leading to the fall for one of 3 residents (R3) reviewed for quality of care in the sample of 4. This failure resulted in R3 becoming unresponsive and sent to the local hospital, where R3 was diagnosed with a traumatic subdural hematoma, subsequently leading to R3's death on 3/14/22. The findings include: R3's resident face sheet documents R3's date of birth was 1/13/43 with an admission date to the facility of 10/30/21. R3's face sheet also listed the following medical diagnoses: encephalopathy, unspecified, chronic obstructive pulmonary disease, Parkinson's disease, weakness, atherosclerotic heart disease, other seizures,	S9999		

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S9999	Continued From page 2 hyperlipidemia, Alzheimer's Disease, unspecified dementia without behavioral disturbance, depressive disorders, paralysis of the vocal cords, anxiety, gastrostomy status, and need for assistance with personal care. R3's most recent fall risk assessment tool was completed on 2/13/22 and documents a total fall risk score of 7, which falls into the moderate fall risk category. R3's most recent quarterly Minimum Data Set (MDS) assessment dated 1/20/22, Section C, documents a Brief Interview for Mental Status (BIMS) score of 13, indicating R3 is cognitively intact. This same MDS documents in Section G that R3 requires extensive assist (of two plus person physical assist) for the following: bed mobility (how a resident moves to and from lying position, turns side to side, and position body while in bed or alternate sleep furniture), transfer (how the resident moves between surfaces including to or from: bed, chair, wheelchair, standing position), locomotion on unit (how resident moves between location in his/her room and adjacent corridor on same floor), locomotion off unit (how resident moves to and returns from off unit locations like dining room, activities and treatment areas), dressing (how a resident puts on, fastens and takes off all clothing items), toilet use, and personal hygiene. This same section of the MDS also indicates that R3 did not walk in room or corridor during the look back period of this assessment. Section G0300 indicates that R3 needed staff to assist in stabilizing when moving from seated to standing position, while moving off and on the toilet, and when moving from surface to surface. G0600 indicates that a wheelchair was normally used as a mobility device. Section H of this MDS indicates that R3	S9999		

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S9999	Continued From page 3	S9999		

was occasionally incontinent of urine and bowel and was not on a toileting program. Section J1800 is coded for R3 to have not experienced any falls since admission/entry or re-entry to facility. Section O indicates that R3 received active range of motion 7 days a week and received bed mobility training and skill practice for 7 days a week during that 7 day look back period. Section P indicates that R3 has no restraints or alarms.

R3's care plan has a problem area with a start date of 11/18/21 documenting a potential for complications related to anticoagulant therapy. The goal is to have no active bleeding and the approaches include: administer medications, monitor lab work, monitor vital signs, and observe for active bleeding. A problem area dated 10/30/21 under category disease process lists resident has a diagnosis of Parkinson's and is at risk for complications. The goal with a target date of 4/20/22 is that R3 will be free of complications (injuries from shuffling gait). The approaches to this problem area include: activities as tolerated by choice, call light within reach, clutter free environment, encourage family involvement, notify MD (medical doctor) of changes, observe for safety, therapy evaluation as ordered, provide assist for daily care and mobility, provide medications as ordered and monitor effectiveness. A problem area with a start date of 10/30/21 includes R3 is unable to participate in activities of daily living (ADL) secondary to weakness. The goal date of 4/20/22 documents R3 will have met all ADL needs until next review date. The approaches include: call light within reach while in room and remind resident to call for assistance, explain all procedures to resident, meet grooming needs/hygiene/nails/skin, provide care for resident and provide privacy for care.

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S9999	Continued From page 4 Problem category with start date of 10/30/21 for Falls documents R3 is at risk for falls. Goal is for R3 to be free from falls. Approaches to this problem are to: assess and treat postural/orthostatic hypotension, implement exercise program that targets strength, gait and balance, increased staff supervision with intensity based on resident need, medication review to reduce fall risk, and provide individualized toileting interventions based on needs/patterns. R3's nursing progress notes in the medical record have no entries from 3/10/22 through 3/11/22. The last note entered was 3/9/22 at 2:23 AM regarding R3's skin condition, and there is nothing else entered until a late entry recorded on 3/13/22 at 3:21 PM by V14 (former Licensed Practical Nurse/LPN) documenting that on 3/12/22 at 8:00 AM during morning med pass, R3 was noted to be sleeping soundly. Upon administering morning medication through feeding tube, resident awoke and talked briefly to the nurse. When this nurse went in the room again approximately 30 minutes later to change feeding tube dressing, a small amount of emesis was noted on beard. Staff notified and cleaned resident. Feeding tube stopped for 2 hours due to emesis and head of bed stayed at 90 degrees due to aspiration precaution. There are no further progress notes found in the medical record documenting R3's tube feeding being restarted, vitals being taken, or notes on R3's condition until he is found unresponsive at 4:20PM. On 3/12/22 at 4:20 PM, V2 (Director of Nursing/DON) documents in nursing progress notes arrival to guest room to assess patient. Guest (R3) found with snoring respirations and gurgling. Guest suctioned no response. Small amount of thick yellow sputum removed. Respirations sound improved. Sternal rub performed and guest	S9999		

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S9999	Continued From page 5 unresponsive. Left pupil 1 millimeter and right pupil 4 millimeters and responsive to light. No response to commands. Nurse practitioner notified and guest sent out. On 3/12/22 at 4:29 PM, EMS (Emergency Medical Services) called to transport guest. On 3/12/22 at 4:43 PM, V14 (LPN) documented that during evening medication pass resident noted unresponsive. Upon assessment audible gurgling noted. V2 notified and assisted nurse. R3 was suctioned. Gurgling continued after suction. R3 was non-responsive to a sternal rub. Vitals were as follows: 100/60 blood pressure, temperature 98.4, Oxygen saturation 75 percent on 5 Liters of oxygen, pulse 63 and respirations 22. Physician notified, ambulance called, local hospital called, and report given. Ambulance arrives and transports R3 at this time. On 3/12/22 at 4:47 PM, V14 attempts to call family to notify of R3 being transferred to local emergency department. On 3/12/22 at 5:41 PM, V14 documents that local hospital emergency department nurse called and asks nurse several questions regarding R3. Hospital nurse states that R3 has a brain bleed and was asking if he had any recent falls. V14 stated that no falls were noted. Hospital nurse then asks how R3 was today and V14 replies that he was awake this morning at approximately 8 AM and his morning medications were pushed through his feeding tube. Resident normally naps periodically throughout the day so R3 was not acting out of usual behavior until he was noted to be gurgling and non- responsive at approximately 4:30 PM. This is why R3 was sent to the hospital due to abnormal vital signs and behavior. R3's last progress note, from 3/13/22 at 12:36 PM by V14 documented R3 was in hospital on a ventilator, unresponsive with a diagnosis of a brain bleed. No further updates at this time.	S9999		

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S9999	Continued From page 6 March 2022 Physician Orders for R3 included aspirin 81 milligrams once a morning and Eliquis 5 milligrams twice a day. Progress notes from the local hospital emergency room made by V19 (Emergency Room Physician) document provider notes made on 3/12/22, under the history and physical, "neurology referred to trauma as SDH (subdural hematoma) implies trauma. Trauma suggested neuro-management, no evidence of trauma and neurosurgery consult. Neurosurgery suggested non-operative management and to propose comfort measures as injury is non-salvageable. Spouse (V7) explained that there was in fact trauma last night (3/11/22) but the patient was not taken to the local emergency room by the nursing home per spouse (R3)." This same note states that R3 arrived via medical transport "unresponsive and low oxygen in the 70s." The computed tomography (CT) scan from 3/12/22 lists the 'findings' as: There is a very large acute subdural hemorrhage over the right temporal and frontoparietal convexity measuring up to about 1.2 centimeters in thickness. There is also acute hemorrhage along the anterior falx. On 4/13/22 at 10:54 AM, V19 (ER Physician) stated that a fall regarding R3 was reported to the emergency department by V7 (Family Member) due to R3 not being responsive when he arrived to the ER. V19 stated that after a discussion with other physicians in the ED (emergency department), it was determined to send R3 to the neurology team due to the brain bleed. V19 stated that this type of bleed is most commonly associated with some sort of trauma to the head and not a spontaneous bleed. V19 said the facility where R3 lived was contacted, and they were unable to give any information of an event where	S9999		

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S9999	Continued From page 7 the resident would have received this trauma to his head. When asked about delay of treatment for such an injury regarding outcomes, V19 stated he can't say with complete certainty, but it is always better to bring a person in immediately rather than wait, in order to have more positive outcomes after an injury. Progress notes from the receiving local hospital after a transfer from the ER documents the following on 3/13/22 in the history of present illness by V6 (neurologist): Head CT with large right hemispheric traumatic subdural hematoma with midline shift, cerebral herniation, and infarction. Trauma was contacted and directed the ER to call neurology because there was no evidence of visible trauma. The same progress notes under the section of "Neurology attending assessment and recommendations" documents the following: in brief, R3 has a traumatic right hemispheric subdural hematoma causing a 1.2 centimeter shift, uncal herniation, and right infarction. The midbrain is compressed and hypodense. R3 had a fall the day prior. Not a surgical candidate due to prolonged down time and abysmal neurological exam. This is a critically ill patient. A progress note dated 3/14/22 by V22 (Neurologist) documents that the family of R3 had decided to make the resident comfort care and are waiting for family to arrive. On 4/13/22 at 5:00 PM, V6 (Physician) stated that he was the admitting physician for R3 to the hospital where he was transferred to be closer to V7 (Family Member) because of her hospitalization too. V6 stated that (V7) reported R3 had told her he fell on 3/11/22. V6 stated that when he received R3 as a patient on 3/13/22, that he was in a coma and not responsive. V6 said that the herniation in R3's brain had resulted from	S9999		

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a trauma, likely the fall the wife reported, which caused the hemorrhage to occur in his brain. V6 stated that this type of brain bleed is not common from a spontaneous bleed, that some sort of trauma would cause this subdural hematoma that hemorrhaged, and then led to the herniation.

R3's "Certificate of Death Worksheet" signed by V22 (Neurologist) documents that R3's date of death was 3/14/22. The cause of death was: subdural hematoma, traumatic and documents that this injury was caused by a ground level fall at the nursing home that R3 resided in.

On 4/12/22 at 9:00 AM, V7 (family) stated that she had spoken to R3 at 10:30 PM on 3/11/22. V7 said she, herself had been admitted to a local hospital, and she was calling (R3) to let him know that she was admitted. V7 stated that her mother had called R3 at 6:30 PM to let (R3) know she (V7) was being sent to the hospital. At 10:30 PM, while on the phone, R3 stated that he had fallen that day by slipping in urine and hurt his neck. V7 stated that she asked (R3) why he was not sent to the hospital, and R3 stated he promised he would be ok. V7 stated that she asked him why he was not sent to the hospital and R3 stated he promised he would be ok and not to worry. V7 stated she now knows this was a mistake listening to him (R3), and she should have called the facility, but she had just been admitted to the hospital after an Emergency Room visit, as they thought she was having a stroke herself. V7 said she then called him the next morning and R3 did not answer, but she was not concerned because she thought maybe he was sleeping or couldn't reach his phone. However, the next call she received was from the hospital asking for consent to treat and she had no idea that R3 had been transferred to the hospital. V7 stated that R3 did

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not tell her who picked him up or what time for sure, but that he had fallen in urine and layed for a while before someone got him up. V7 stated she assumes that the fall had not happened at 6:30 PM when her mother had called (R3) to let him know she (V7) was being transferred to the hospital, as R3 did not mention it at that time, but when (V7) spoke to (R3) at 10:30 PM, he reported the fall to her.

On 4/12/22 at 11:00 AM, V2 (Director of Nursing/DON) stated that he was the RN working on 3/12/22 on the rehabilitation side. V2 said he was called over by V14 (LPN) to assess a resident (R3) she found non-responsive. R3's vitals were off, his pupils were not reactive and V2 stated to send R3 to the ED. V2 stated that the hospital did call later and ask about R3's behaviors of the day and about any recent falls, of which none were reported, so they had no information to give. V2 stated that when he came to check (R3's) condition on 3/12/22, he did not do a full body assessment at that time but did not see any visual markings to indicate R3 had a fall. V2 stated that when a resident is transferred out of the facility, the family or POA should be notified. No type of assessment or form was done at this time other than sending medication, face sheet and bed hold policy. R3 has resided in the facility since October and has no documented falls, and he is unaware of any. R3's spouse was planning on taking him home once she was well enough. R3 had dysphagia and was on blood thinners. V2 stated he talked to staff after the hospital called and inquired about a possible fall, but he did not document these conversations because no one knew of a fall. V2 said nothing was reported to IDPH (Illinois Department of Public Health) either or investigation of any kind.

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S9999	Continued From page 10 On 4/12/22 at 12:00 PM, V3 (Assistant Director of Nursing/ADON) stated that R3 would not have had the strength to get up on his own after a fall. V3 stated that R3 was not confused and has not had a reported or documented fall since admit in October of 2021. V3 said that R3 used his call light when he needed assistance all the time and did not try to self-ambulate. R3 was able to ambulate with a gait belt and supervision, and a wheelchair behind him in case he would get tired or weak while walking. V3 stated that she is unaware of a fall that R3 supposedly had. V3 said she was never told of one, nor has she ever investigated one. V3 stated that when a fall occurs, the person who finds the resident should alert a nurse, if that person is not a nurse, have the nurse do an assessment, and then do as the nurse instructs, whether that be to assist up off the floor or call 911. A fall report and investigation is then completed on all resident falls and a note in the chart. On 4/14/22 at 10:08 AM, V5 (Previous Administrator) stated that she recalls hearing that R3 may have had a fall but is unsure when or who would have told her that. V5 said that it could have been from the hospital calling and questioning a potential fall, but that she had done an 'investigation' into this and found that no one knew of a fall. V5 admitted that her investigation was not written down, it was just that she asked a couple CNA's (Certified Nurse Aides) and probably a nurse and no one reported a fall. V5 said she does not remember who she spoke to when she asked about R3 falling. According to the staffing schedule provided by V3 (ADON), the following staff were assigned to work the wing where R3 resided on the day shift 6am-6pm on 3/11/22: V17 (LPN) and V23	S9999		

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S9999	Continued From page 11 (Nursing Assistant). On 4/20/22 at 12:45PM, V3 (ADON) stated that V16 (CNA Supervisor/Transport) filled in on this shift due to CNA call-offs. On 4/13/22 at 9:45 AM, V17 (LPN) stated that she is unaware of any falls that R3 would have had at the facility. V17 stated R3 always asked for help and used his call light. After several attempts made by both surveyor and facility, V23 was never able to be reached for a phone interview. On 4/13/22 at 9:30 AM, V16 (CNA) stated that R3 was unable to even sit up in his bed without assistance. V16 said once R3 was assisted out of bed and given his walker, he then was able to ambulate with a gait belt and supervision. V16 said R3 was a very careful man and always used his call light. He was not confused, and she had never known of him falling. According to the staffing schedule provided by V3 (ADON), the following staff were assigned to work the wing where R3 resided on the evening shift, either from 2pm-10pm or 6pm-6am on 3/11/22: V8 (Nursing Assistant) was documented as working from 2pm-10pm, V18 (Nursing Assistant at the time/now a CNA) was documented as working from 6pm-6am, and V21 (LPN) was documented as working from 6pm-6am. Per email communication with V1 (Administrator) on 4/19/22, V1 verified that V18 was a Nursing Assistant on 3/11/22 but officially became a Certified Nursing Assistant on 3/30/22. On 4/20/22 at 9:30 AM, V3 stated that V20 (CNA) would have been the CNA that floated down to cover (R3's wing) that evening.	S9999		

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S9999	Continued From page 12 On 4/14/22 at 9:20 AM, V8 stated although it has been a while since March 11, but off the top of his head he does recall R3 having a fall but is unsure of what the date would have been. V8 went on to ask if he needed to contact a lawyer. V8 stated that he did work the night shift of March 11, 2022 and remembers hearing about a fall happening at some point but was unsure of when or where it happened and was not involved in helping R3 up or reporting it. V8 said he assumed he was on the other side of the building and otherwise busy. On 4/13/22 at 10:37 AM, V18 (former NA/current CNA) stated that she had worked 3/11/22 from 6pm-6am and never knew of R3 ever having a fall. V18 stated that R3 never had any markings like bruising from an unreported fall. V18 stated R3 was very good about not self-ambulating and always asked for help when he needed up. On 4/14/22 at 3:00 PM, V21 (LPN) stated that she took care of R3 on the evening shift of 3/11/22. V21 said she never heard of a reported fall, nor had knowledge of anyone getting him up from a fall. V21 said R3 showed no signs of any reason for alarm in his mental status while she took care of him throughout the night shift. On 4/20/22 at 5:30 AM, V21 stated that she does not remember who she even worked with on the evening shift of 3/11/22 or their credentials. V21 went on to state that while it is never scheduled to have only nursing assistants work on a hall it can sometimes happen with call offs. If this is the case, then they would have a float CNA come from the rehabilitation side or the nurse would assist the nursing assistants with whatever needs to be done with the residents.	S9999		

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On 4/13/22 at 11:00 AM, V20 (CNA) stated that he had worked the 6p-6a shift on 3/11/22 on the rehabilitation side of the facility, and R3 lived on the Long Term Care side of the facility. V20 said he does not recall R3 ever having a fall while he lived in the facility. R3 was dependent on help getting to the standing position and out of bed, and he always used a call light and was careful.

According to the staff schedule provided by V3, the following staff were familiar R3, but were not assigned to work R3's wing and instead worked the rehabilitation wing on the day shift of 3/11/22: V9 (RN) and V15 (CNA).

On 4/14/22 at 9:15 AM, V9 (Registered Nurse/RN) stated that she did work the 6am to 6pm shift on 3/11/22, but works on the rehabilitation side of the facility, which is separate from the Long Term Care side. V9 stated that she had not heard of R3 falling and was never asked to come assess or assist with a resident fall on the Long Term Care side of the facility. V9 stated when she worked with R3 on the rehabilitation side of the facility, he was good about always asking for help when getting up. V9 stated R3 always had his call light, his cell phone, and a tissue on his table. V9 stated that R3 was able to ambulate with a gait belt with stand by assistance but needed help standing up to get to his walker.

On 4/13/22 at 9:11 AM, V15 (CNA) stated that she worked on 3/11/22 from 6p-6a. V15 was assigned to the rehabilitation side of the facility, opposite side from where R3 was on the Long Term Care side. R3 was a compliant resident who used his call light. V15 stated that R3 would not have been able to get himself up off the ground if he had fallen, and it would likely take 2-3 people to get him up considering his size of stature. R3

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was very soft spoken and likely would not have been heard had he yelled for help. V15 said R3 had no marks of injury that she recalls, like bruising or abrasions, nor did he mention he had had a fall. V15 said if a resident is ever found to have fallen or potentially injured themselves, the person who finds the resident, if not a nurse, is to alert a nurse to assess the resident for injury, and then notify administration, physician, family and 911 if necessary. V15 said no one is to ever get a resident up without proper assessment of injury and this should also then be documented in the medical record and investigated.

According to the staff schedule provided by V3, the following staff were familiar with R3, but were not assigned to work R3's wing and instead worked the rehabilitation wing on the evening shift of 3/11/22: V10 (LPN), V11 (CNA).

On 4/14/22 at 9:05 AM, V10 (LPN) stated that she was unaware of any incident involving R3 falling. V10 worked on the rehabilitation side of the facility on 3/11/22 from 6pm-6am. V10 was never asked to come over and assess or assist with R3. V10 stated that she worked with R3 when he was on the rehabilitation side of the facility, and he was always good about using his call light and not getting up on his own. V10 went on to state that R3 was likely unable to get up on his own without the assistance of others, and it would take 2-3 people to get R3 up due to size.

On 4/14/22 at 8:50 AM, V11 (CNA) stated that she worked the rehabilitation side of the facility on 3/11/22 from 6pm-6am. V11 stated that she had heard a rumor that R3 fell but does not know if it was true. V11 said she did not see R3 fall nor was she asked for help to get R3 up. V11 stated that R3 would require the help of more than one

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person to assist up off the floor and he would not have the strength to get up on his own. V11 stated R3 always used his call light for assistance.

According to the staffing schedule provided by V3, the following staff were assigned to work the wing where R3 resided on 3/12/22 from 6am-6pm: V12 (CNA), V14 (LPN), and V23 (Nursing Assistant).

On 4/12/22 at 2:43 PM, V12 (CNA) stated that R3 was tube fed, was able to walk with supervision and was able to state his needs. V12 said R3 was not confused and did not attempt to get up without help. R3 always used the call light to get assistance and was never known to have a fall in the facility. V12 said if R3 would have fallen, it is unlikely that he would have had the strength to get up alone. V12 stated R3 did not have a roommate and the resident next to him is deaf and blind. V12 said R3 used his call light all the time, but the main things he would need would be his phone, his urinal or he was ready for a walk. V12 said R3 was a very clean man, and it would be a surprise if he had urine on the floor.

On 4/12/22 at 2:00 PM, V14 (former LPN) stated that she was the nurse that worked on 3/12/22 when R3 was sent to the hospital. V14 said it was not uncommon for R3 to nap off and on during the day. When she passes medications or gives a feeding though R3's tube or does nebulizer treatments, he generally would acknowledge her in the room and maybe talk a little. V14 stated that when she went to give R3's evening feeding, he was not acting right or responsive. V14 called down V2 to report R3's change of status and V2 recommended sending R3 to the ED. The hospital called a little while later asking if R3 had

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fallen. V14 said nothing was in the chart or reported to her, so she had no information to give the hospital. V14 states that R3 was not confused and was able to communicate and feels that he would have told her if something would have happened. V14 said R3 did have a little emesis that morning, but she contributed it to a possible 'bug' in the facility and stopped the tube feeding for 2 hours and restarted it with no issue. R3's feeding tube site showed no issue or trauma from being pulled at. V14 stated R3 always used his call light for his needs and never got up alone. R3 used a walker to ambulate, and someone was always there for safety. R3 knew his limitations and always acted with safety. V14 said R3 would have not had the strength to get up on his own, and it would have likely taken a couple people to get him up because he was very top heavy. R3's vitals and mental status were the reasons they transferred him to the ED on 3/12/22. V14 said R3 was sent out as soon as his vitals were crashing, and he was not responsive.

As noted above, V23 was never able to be contacted after several attempts were made to reach her throughout the survey.

On 3/12/22 the following staff V13 (CNA) worked the day shift on the rehabilitation side of the facility along with V2 (DON).

According to the staff schedule provided by V3, the following staff was familiar with R3, but was not assigned to work R3's wing and instead worked the rehabilitation wing on 3/12/22 from 6am-6pm: V13 (CNA)

On 4/12/22 at 12:35 PM, V13 (CNA) stated that she worked on the rehab side of the facility the day (R3) was transferred to the hospital on

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3/12/22. V13 stated that she does not recall a fall with R3, but that he was not confused so if he said he fell, he probably did. V13 stated that R3 was good with using his call light to ask for help, and when he rang, it was because he needed his urinal, his phone or was ready to go for a walk. V13 said R3 needed help getting up and needed a gait belt for safety but was pretty steady on his feet once he got up. V13 said if a resident was found on the floor or was a witnessed fall, the CNA and NA's would call for a nurse to do an assessment prior to getting the resident up and wait for instruction from nurse on what to do next. This should then be documented somewhere in the chart.

The following staff was also familiar with R3's care, but were not on the staff schedule to care for R3 on 3/11/22 or 3/12/22: V4 (Therapy Manager) and V24(LPN).

On 4/12/22 at 11:37 AM, V4 (Therapy Manager) stated that R3 discharged from therapy on January 19, 2021. Prior to that, R3 had been receiving therapy since October when he was admitted into the facility. At the time of discharge, therapy determined that R3 had reached his max potential. On the 9th of March, they were beginning to reassess R3 to start therapy back so when he went home, he would be ready to go. OT (Occupational Therapy) did not get the assessment done, but PT (Physical Therapy) did and was going to restart.

On 4/20/22 at 12:00 PM, V24 (LPN) stated that when she took care of R3 he tolerated his g-tube feedings with no issues. V24 said if a resident on a tube feeding has emesis, normally it would be stopped for at least one hour, and the doctor would be called to get further direction. Vitals

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would normally be taken at that time too to try to determine what is causing the emesis. V24 stated the vital signs taken would then be recorded in the progress notes. V24 verified the schedule was correct that she did not work 3/11/22 and came on evening shift on 3/12/22 after R3 was sent to the hospital emergency room.

A document titled "Falls Management" dated February 2012 under the heading 'Policy' documents the following: It is the policy of Helia Healthcare to assess and manage resident falls through prevention, investigation, and implementation and evaluation of interventions. Under the heading 'definition' it documents: Fall, for purposes of this policy, means any time the resident is actually witnessed falling to the ground or is found on the floor. It also includes when a resident is lowered to the floor or rolls out of a low bed. A document titled "Neurological Assessment" dated February 2012 stated under the heading "Policy" the following: The purpose of this procedure is to provide guidelines for a neurological assessment: 1) upon physician order; 2) when following an unwitnessed fall; 3) subsequent to a fall with a suspected head injury; or 4) when indicated by resident condition. "General Guidelines" of this document state to: Neurological assessments are indicated: Upon physician order; Following an unwitnessed fall; Following a fall or other accident/injury involving head trauma; or when indicated by resident's condition. When assessing neurological status, always include frequent vital signs. Particular attention should be paid to widening pulse pressure (difference between systolic and diastolic pressures). This may be indicative of increasing intracranial pressure (ICP). Any change in vital signs or /neurological status in a previously stable resident should be reported to

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S9999	Continued From page 19 the physician immediately. Under the 'Documentation' heading of the document it states: The following information should be recorded in the resident's medical record: The date and time the procedure was performed. The name and title of the individual(s) who performed the procedure. All assessment data obtained during the procedure. How the resident tolerated the procedure. If the resident refused the procedure, the reason(s) why and the intervention taken. The signature and title of the person recordingthe data. Under 'Reporting' the policy documents to: Notify the physician of any change in a resident's neurological status. Notify the supervisor if the resident refuses the procedure. Report other information in accordance with facility policy and professional standards of practice. (A)	S9999		