STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006191	A. BUILDING: _____ B. WING _____	05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE NILES	8333 WEST GOLF ROAD NILES, IL 60714

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S 000	Initial Comments Annual Health Certification Survey FRI of 4/27/2022\IL146417 & FRI of 4/22/2022\IL146248	S 000		
S9999	Final Observations 1 of 3 Licensure Violations Statement of Licensure Violations: 300.1210b) 300.1210c) 300.3240e) 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. Section 300.3240 Abuse and Neglect e) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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) This Requirements wer NOT MET as evidenced by: Based on interviews and record reviews, the facility failed to keep residents free from physical and sexual abuse. This failure affected two (R50 and R187) of four residents reviewed for abuse and resulted in R50 being physically abused by another resident and R187 experiencing fear while being touched inappropriately by another resident. Findings include: R187 is a 46 year old female, admitted in the facility with diagnosis of Major Depressive Disorder, Single Episode, Unspecified. MDS (Minimum Data Set) dated 03/18/2022 under Section C indicated that R187 has BIMS (Brief Interview for Mental Status) score of 15 which means intact cognition. According to abuse report dated 04/24/2022, R143 admitted to inappropriate touching R187 above clothing and flashing without her (R187) consent. On 05/10/2022 at 11:40 AM, R187 was asked regarding incident with R143. R187 stated, "It happened in my room. He went to my room and got into my bed, put his hand into my mouth so I couldn't scream. He started touching me, my breasts. I started crying and told him to stop. It was a little scary at that time. He stopped and left the room. I went to the nurse and report it right away. The nurse checked me. I don't have any	S9999		

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S9999	Continued From page 2 injuries or anything. I am not scared of him." Final Investigation report dated 04/29/2022 read: R143 stated during interview: I sometimes go into her room and I want to touch her. I attempted to touch on top of her pants and her breasts, but she pulled away and told me to get out of the room. R187's Progress notes dated 04/26/2022 authored by V16 (Nurse Practitioner) documented: Assessment/Plan: 12. Incident with another resident: Patient (R187) was touched inappropriately by another male resident at night while she was sleeping; patient reports no health concerns resulted from above. V8 (Registered Nurse, RN) was interviewed on 05/11/2022 at 10:24 AM regarding R187 incident with R143. V8 verbalized, "The incident happened on 04/24/2022, around noon. I was doing my medication pass, I saw him (R143) with her (R187) in her (R187) room. He was talking to her but I was not listening. I remember she was feeling uncomfortable, she was looking at me like she was asking for my help to tell him (R143) to leave the room. I escorted him out of the room. He has Schizoaffective disorder, sometimes he says intrusive thoughts out loud, or talks to himself. She is always calm, nice and cooperative. As a nurse, we don't allow male residents to come into female residents' rooms for safety precautions. Sexual advances may occur. We do rounds every hour to check, talk to residents and redirect them." R143 has a diagnosis of Schizoaffective Disorder, Depressive Type, per his face sheet. On 05/11/2022 at 11:32 AM, V21 (Director of	S9999		

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S9999	Continued From page 3 Social Services) stated in an interview that R143 admitted that he went to her room and tried touching her (R186) private parts. V21 continued, "I asked her (R187) about the incident and she told me that it happened earlier in the day. She said she was sleeping, she woke up and he was standing there and was trying to touch her private areas, the breasts and was trying to put his hand inside her pants. She was assessed, I told V1 (Administrator) everything. I called paramedics and local authorities also came. During interviews by local authorities, she stated that he (R143) had his genitalia out while he was trying to touch her which she did not tell me during the interview. She said she did not say anything to me or to the nurse because she is afraid that he would kill her if she said anything. It makes sense because she did not tell me everything until I asked her. I am not aware of any rules in the facility that male residents are not allowed in female residents' rooms. Residents have rights but there should be some kind of boundaries between male and female residents when male residents going into female residents' rooms. Activities, CNAs (Certified Nurse Assistants) rand nurses need to be inserviced of the boundaries of male entering female rooms and vice versa, privacy, redirection, supervision and monitoring from staff. CNAs are supposed to do rounds as often as necessary to ensure privacy and safety of other residents." Involuntary Petition dated 04/24/2022 documented in part but not limited to the following: R143 was displaying sexually inappropriate behaviors and language towards a female peer. R143 confessed to exposing his genitalia and attempting to touch peer's breast and vaginal area. R143 often displays sexually abusive language, sexually threatening language and explicit/inappropriate language towards	S9999		

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S9999	Continued From page 4 female peers. R143 expressed having overthinking, and auditory hallucinations stating, "voices in my head are telling me to do bad things." R143 is a danger to peers and requires immediate hospitalization. On 05/11/022 at 1:13 PM, V3 was asked regarding interventions in preventing sexual abuse among residents in the facility. V3 stated, "We need to set boundaries on female residents being visited or male residents coming into room; inform residents regarding interaction in the room or with supervision. Staff needs to intervene, ask if it was an invitation, especially if there are other residents residing in the room. Staff needs to monitor residents every two hours or as needed to ensure residents' needs are met and for safety purposes." V3 also added, "He (R143) has Schizoaffective disorder. We need to monitor behavior and management for Schizophrenia. We need to supervise him and monitor regardless if there is a behavior or not because of his mental illness, medical illness and for psychotic episodes. He is alert, oriented and easily redirectable and can understand instructions. Just need guidance and monitoring." V1 (Administrator) also mentioned during interview on 05/11/22 at 2:43 PM, "We always have an adequate amount of staff supervising and monitoring residents to ensure patients' needs are met, male residents roaming around or going into female residents' rooms without permission. Staff is constantly doing rounds in a shift and they do redirect residents when needed. We need to monitor and supervise residents with mental illness and redirect them. We monitor all residents and supervise them as needed and as frequent as possible for safety and prevention of incidents and redirection as necessary."	S9999		

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S9999	Continued From page 5 R187's Care Plan dated 04/12/22 documented: The resident may voice allegations of mistreatment or exploitation. Interventions: assess the resident that they are safe and secure. Assure them that their needs will be addressed by trained caregivers. Keep the resident's representative informed about the behavior and staff interventions strategies, as appropriate; Investigate statements/allegations. Facility's policy titled "Abuse Prevention and Reporting - Illinois" reviewed date 12/17/2021, documented in part but not limited to the following: Guidelines: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Establishing a Resident Sensitive Environment This facility desires to prevent abuse, neglect, exploitation, mistreatment and misappropriation of resident property by establishing a resident sensitive and resident secure environment. This will be accomplished by a comprehensive quality management approach involving the following: Resident Assessment: As part of the resident social history evaluation and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment or misappropriation of resident property, or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals and approaches, which would reduce the chances of abuse, neglect, exploitation, mistreatment or misappropriation of resident property for these residents. Staff will continue to monitor the goals and approaches on a regular basis.	S9999		

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S9999	Continued From page 6 (B) 2 of 3 300.610a) 300.1210b) 300.1210c) 300.1210d)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 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	S9999		

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S9999	Continued From page 7 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: 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 Requirments were NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to 1.) prevent a resident (R98) from developing moisture associated skin dermatitis related to incontinence and 2.) failed to assess and treat a neck wound for a resident (R173) at the time of admission. These failures affected two out of 10 residents reviewed for pressure ulcers and resulted in R173 having a delay in treatment for a neck wound, which progressed to a Stage III pressure ulcer. Findings include: R98 is a 64-year-old female admitted to the facility 07/05/2017 with diagnoses that include, chronic respiratory failure, diabetes, weakness and hypertension. R98 is alert and oriented but is	S9999		

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S9999	Continued From page 8 unable to make needs known to staff as noted during observation and interview attempts. On 05/09/22 at 12:18PM R98 was observed in bed, with bilateral lower leg contractions, and heels resting on the mattress. The right heel was red in color and had noticeable skin peeling. R98 had on a disposable brief and sheets were observed to be soiled from underneath. On 5/10/22 at approximately 10:50 AM V22 Wound Care Coordinator said, the nurses are supposed to look at the skin and document on days that the residents get showers. The Certified nursing assistant will put if there is a skin issue in the electronic record and the nurse is supposed to follow up and assess. They should be documenting weekly on skin observation forms in the electronic record. It would not be beneficial for an air mattress to be covered with a bath blanket on the air mattress or a towel in between the resident and the air mattress because it will impede the healing process of the mattress. It should only be covered with a flat sheet. 5/10/22 at 11:40 AM R98 was observed receiving incontinence care before conducting a skin assessment with V22 Wound Care Coordinator. V28 and V29 Certified Nursing Assistants were observed changing R98 and there was a foul odor coming from the sheets, the brief was saturated and the sheets were soaked in urine and feces. V28 said I last changed her at 8am today. While repositioning for care, a soiled bath towel was noted in between the mattress and the flat sheet. The air mattress was saturated as well. R98's skin was observed to be reddened in color with multiple areas of open skin in areas of the sacrum, coccyx and labia. V22 said, I would	S9999		

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S9999	Continued From page 9	S9999		

assess this as moisture associated skin dermatitis in the perianal and scattered open areas caused by incontinence. R98 being wet for an extended period of time will certainly have accelerated this skin breakdown. It could have been prevented with frequent changes and repositioning.

R98's Care Plan for Wound Care documents that R98 is high risk for skin breakdown related to immobility; Bowel and Bladder Incontinence and use of anti-coagulation therapy.

Facility did not present weekly skin assessment notes upon request.

R173 is a 65-year-old woman admitted to the facility 03/04/22 with diagnoses that include; tracheostomy, multiple sclerosis and functional quadriplegia. R173 was admitted with a tracheostomy and required a ventilator for primary respiration. R173 was not able to be interviewed as she is not alert or oriented. She is unable to make her needs known to staff.

Initial comprehensive nursing assessment dated 03/04/22 documents that R173 had 1 skin alteration, a Stage IV pressure ulcer to the sacrum. In an initial respiratory note written for the same day, 3/4/22, it was noted that R173 also had a wound on the neck, and that nursing would be advised of the wound. There was no further assessment by nursing or wound care noted until 3/17/22.

On 3/17/22 at 11:47AM, a wound assessment and details report documents that R173 had a Stage III pressure ulcer of the back of neck bright pink or red in color with serous exudate measuring 3.0 x 1.50 x 0.20 cm^2 (length x width

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S9999	Continued From page 10 x depth). The assessment states that the wound was present on admission. Physician Order Sheet dated 3/17/22 included orders for cleansing, med honey and foam dressing to be changed daily and as needed for back of the neck wound. Care plan initiated 3/7/22 and revised 3/17/22 said that R173 required wound care due to pressure injury to sacrum and back of neck upon admission. On 05/12/22 10:27 AM V22 Wound Care Coordinator said, the nursing and wound care team did not assess the wound on the back of the neck until 3/17/22. Although the wound was noticed by the Respiratory Therapist, they are not able to assess a skin issue. The nurse is supposed to assess. Since there was no assessment, there is no way of determining what type of wound was present and therefore did not have any treatment orders in place. By the time the wound care team saw R173, the wound was a Stage III. 05/12/22 12:45 PM V31 Wound Care MD said, The back of the neck wounds, when they open up, the skin opens very fast. I have no idea how old the wound was. Once a wound was identified, the treatment should be placed with urgency. Moisture Associated Skin Dermatitis (MASD) cause is secondary to exposure of body fluids including feces and urine. This could certainly transform into a pressure ulcer without treatment. MASD could have open skin with undefined edges and any moisture causes the skin to swell and skin breaks down. Facility Pressure Ulcer Prevention policy revised	S9999		

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S9999	Continued From page 11 1/15/18 reviewed and states in part; Purpose: to prevent and treat pressure sores/pressure injury. 3. Change bed linen per schedule and whenever soiled with urine, feces or other material. Turn dependent resident approximately every two hours or as needed and position resident with pillow or pads protecting bony prominences as indicated. Facility policy titled Wound Care Program: Pressure injury and Skin Condition Assessment revised 11/29/20 states in part, 2. Residents identified will have a weekly skin assessment by a licensed nurse; 3. A wound assessment will be initiated and documented in the resident chart when pressure and/or other ulcers are identified by licensed nurse; 4. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment; 6. Care givers are responsible for properly notifying the charge nurse of skin breakdown; 7. At the earliest sign of a pressure injury or other skin problem, the resident, legal representative, and attending physician will be notified. The initial observation of the ulcer or skin breakdown will also be described in the nursing progress notes. (B) 3 of 3 300.610a) 3001210b) 300.1210c) 300.120d)6 Section 300.610 Resident Care Policies	S9999		

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S9999	Continued From page 12 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. 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	S9999		

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S9999	Continued From page 13 that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were NOT MET as evidenced by: Based on interviews and record reviews, the facility failed to provide required supervision and monitoring of residents assessed to require staff supervision according to their plan of care . This failure affected one (174) of three residents reviewed for accidents and supervision and resulted in R174 subsequently having a fall and having to be transferred to the hospital for a laceration to the forehead that required sutures. Findings include: R174 is 72 years old. Current diagnoses include but are not limited to: Cognitive Communication Deficit, Symptoms and Involving Cognitive Functions Following Unspecified Cerebrovascular Disease, Aphasia, Unsteadiness on feet, and Other Abnormalities of Gait and Mobility. The facility reported incident of 4/27/22 states: Resident (R174) observed crawling on floor by bedside with a laceration to the forehead. Resident (R174) unable to explain what happened. Sent to hospital and sutures applied to the laceration on the forehead. On 05/10/22 at 10:46 AM, Resident # 174 is in lying in bed awake, opening and closing eyes when spoken to. Noted a handrail on the right side of the bed and a half side rail on the left side of the bed. The call light is wrapped around the handrail hanging in front of Resident # 174 while in bed within his reach. R174 has a BIMS score of 3 which indicates cognitive impairment' may be	S9999		

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	IL6006191	A. BUILDING: _____ B. WING _____	05/12/2022

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S9999	Continued From page 14 unable to understand how to use the call light. No fall mat noted on either side of his bed. Resident # 174 is wearing yellow non-slip socks. Review of R174's care plan indicates: Resident # 174 is utilizing half side rails to serve as enabler during repositioning and bed mobility 8/4/2021 Ensure that the mattress is appropriately sized for the selected bed frame Evaluate resident level of independence in repositioning Show to resident or staff how to take full advantage of the side rail for positioning, turning and transfer Resident # 174 is high risk for falls d/t generalized weakness and cognitive impairment secondary to AMS, UTI, Global amnesia, history of CVA (Cardiovascular accident) CKD (Chronic Kidney Disease), HTN (Hypertension), BPH (Benign Prostatic Hyperplasia) and Depression. 10/26/21 Falling leaf provided. o 2/18/22 Continue PT and OT o 4/20/22 Sent out for evaluation. Fall evaluation at hospital. To resume screening from therapy upon return. o 5/1. Sent to ER for evaluation. o Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes as possible. Educate resident/family/caregivers/interdisciplinary team as to causes. o Be sure call light is within reach and encourage resident to use it for assistance as needed Shows on Kardex. o Ensure that resident is wearing appropriate footwear when ambulating or mobilizing in	S9999		

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S9999	Continued From page 15 wheelchair. There are no appropriate individualized interventions documented regarding R174's ability to use the call light. There is no documentation of need for frequent monitoring or supervision. R174's MDS Minimum Data Set dated 4/18/22 documents a BIMS Interview for Mental Status score of 03 out of 15. A score of 0-7 indicates the resident has severe cognitive impairment. Resident # 174's Restorative Care plan states: Resident # 174 presents with a functional deficit in Ambulation, due to: Generalized weakness 8/10/2021. Interventions-Explain program goals and procedure to resident. Shows on Kardex. o Ensure resident is wearing proper footwear. Shows on Kardex. o Apply gait belt to resident's waist. Shows on Kardex. o Resident to continue gait sequence to cover goal distance, as tolerated. o Allow for rest periods, as needed. o Observe for signs/symptoms of fatigue, SOB, pain, discomfort, or intolerance. o Resident to continue gait sequence, with rest periods as needed, until the dining room is reached. No updates were made after his fall on 4/22/22. Resident # 174 presents with a functional deficit in Transfers, related to: Generalized weakness 4/5/2022. Interventions- Review goal and procedure to resident	S9999		

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S9999	Continued From page 16 o Apply gait belt to resident's waist. o Cue & assist resident to place hand(s) on wheelchair arms or edge of bed and place feet flat on the floor. o Cue & assist resident to scoot forward to edge of bed, wheelchair or toilet seat. o Cue resident to lean forward. o Cue resident to push up with hands and feet to come to a stand. Assist as needed. o Pivot on feet until back of knees touch edge of bed, wheelchair or toilet seat. o On standing, cue resident to take short steps toward stronger side to turn until back of knees touch edge of bed, wheelchair or toilet seat. o Staff to assist as needed. No updates were made to this care plan area after the fall on 4/22/22. Review of the risk assessment for fall completed by V3 DON Director of Nursing was reviewed, indicates no injuries noted. On 05/12/22 at 12:24 PM, interview with V3 DON Director of Nursing regarding Resident 174's fall incident facility reported 4/27/22. V3 stated, " The restorative nurse is the fall coordinator, but I am over all the falls for the residents. R174's BIMS score is 3, he's only alert and oriented to himself. He is ambulatory, but his gait is not steady. He shuffles and has poor posture. The incident happened on 4/20, but I reported it on 4/27. He was sent out due to the fall and had a laceration to his forehead. His interventions are low bed, he was screened by PT (physical therapy) for gait mobility and strength. He is on the falling leaf program. He is monitored closely with frequent rounding around the clock by all staff. The rounding is not documented. His aide that night was V35 CNA Certified Nurse	S9999		

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Assistant, and the nurse was V34 RN Registered Nurse. There was another aide on the floor. I have statements from all of them."

What was determined to be the cause of the fall?
V3 DON stated, "It occurred in his room on the floor crawling by the V35 CNA and he went to get the V34 Nurse to see what was wrong with him. R174 had a laceration to his forehead. He got out of bed and fell. It was late at night; his gait was unsteady so I'm not sure the exact cause. He has dementia, his BIMS is 3 and he can only be redirected. He paces and wanders into other rooms."

What are the possible interventions to prevent R174 from falling?
V3 stated, "Monitoring and supervision R174 every 2 hours. He has a behavior of wandering, unsteady gait. We did labs a urinalysis t check for possible urinary tract infection. His medications were reviewed, and he was referred to physical therapy for evaluation again."

On 05/12/22 at 01:04 PM, interview with V33 Rehab Director regarding R174's fall.

V33 stated, "R174 was evaluated upon readmission. He went to the hospital on 4/20/22, we were seeing him before that. He was on therapy at that time when he fell. Right now, he's on restorative. His functional limits are decreased safety awareness, unsteady gait he's not able to follow therapy with using the walker because of his dementia. I wasn't able to educate him with the walker. Staff have to watch him. We provided a wheelchair, but he just gets up and walks. He doesn't know how to use the wheelchair. His bed mobility is contact guard. He can move himself, transfer in bed, get out of bed

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but with unsteady gait. He has a restorative program. We recommended a low bed, no floor mat because if he tries to stand up he is high risk for falls. He is close to the nursing station. To observe him when walking to give him handheld assistance. He needs monitoring due to decreased safety awareness and decreased cognition."

At 2:29 PM V3 stated, The nurse did the assessment for R174, but I did the risk assessment for the fall. V3 was inquired if he was at the facility on the date and time of R174's fall incident. V3 stated, "No, I wasn't here, I just wrote what the nurse told me happened."

Upon review of the change in condition evaluation completed on 4/20/22 at 8:49 PM by V3 DON indicates he completed the assessment.

The initial report sent to IDPH Illinois Department of Public Health states the facility reported incident took place on 4/27/22.
V3 DON did not present the requested nurse assessment of R174 after his fall incident on 4/22/22.
R174 does not have a medical diagnosis of Dementia documented.
V3 DON did not provide any documentation regarding frequent every 2 hour rounding on R174.
R174's 4/19/22 Fall Risk Evaluation indicates a score of 17: At Risk.

The revised 11/21/17 Fall Prevention Program states:
Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of

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S9999	Continued From page 19 falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the program to assure ongoing effectiveness. Guidelines: The fall prevention program includes the following components: methods to identify risk factors, methods to identify residents at risk, assessment time frames, use and implementation of professional standards of practice, immediate change in interventions thaw were successful, notification of physician, family/legal representative, communication with direct care staff members, documentation requirements, adherence to manufacturer's recommendation in use of alarm and medical devices and special care equipment. Care plan incorporates identification of all risk/issue, addresses each fall, interventions are changed with each fall, as appropriate, preventative measures. In addition to the use of Standard Fall Precautions, the following interventions may be implemented for residents identified at risk: The resident will be checked approximately every two hours, or as according to the care plan, to assure they are in a safe position. The frequency of safety monitoring will be determined by the resident's risk factors and the plan of care. Fall/safety interventions may include but are not limited to: Residents will be observed approximately every two hours to ensure the resident is safely positioned in the bed or a chair and provide care as assigned in accordance with the plan of care. R171 is a 91-year-old male admitted to the facility on 02/04/2021 with diagnosis including but not	S9999		

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S9999	Continued From page 20 limited to Vascular Dementia, Essential Hypertension, Personal History of Transient Ischemic Attack, and Cerebral Infarction. According to MDS (Minimum Data Set) dated 04/18/2022 under section C, R171 has a BIMS (Brief Interview of Mental status) score of 3 indicating severe cognitive functioning. 05/11/2022 at 10:24 AM Surveyor interviewed V3 (DON - Director of Nursing) regarding an incident that happened on 05/06/2022 involving R50, V3 stated, "I was told by the nurse that R171 came into R50's room and hit him. V32 (LPN - Licensed Practical Nurse) then evaluated R50, no injuries found, x-ray was ordered. Notified family and the medical director. R171 was sent to the hospital for further evaluation for increased confusion, which resulted in hitting R50. Neither of them are violent, R171 is easily redirectable and it was very unusual for him to hit someone, that's why he was sent for further evaluation." V3 further stated, "That floor (four south - dementia unit) needs more supervision, residents are demented, we're trying to keep them occupied but two demented patients walking into each other sometimes results in an altercation." On 05/12/2022 at 1:35 PM attempted to interview V32 via phone, no answer. Care plan Wandering/Pacing/Roaming dated 04/18/2022 reads in part, "R171 should be assessed for unauthorized departure risk; if staff see that resident is attempting to go into another resident room, gradually show him where his room is and ask him to show you a personal item from his room; and make rounds/room checks to minimize chance of unauthorize leave." (B)	S9999		

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