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	IL6012470	A. BUILDING: _____ B. WING _____	01/02/2024

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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)6) 300.1220 b)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	S9999		

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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.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These requirements are not met as evidenced by:

Based on interview, observation, and record review, the facility failed to assess residents for

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fall precautions, failed to implement appropriate fall interventions, and failed to ensure resident safety during transfers, for 5 of 7 residents (R6, R8, R10, R20, R27) reviewed for falls and transfers in the sample of 44. This failure resulted in R6 having a fractured left hip and having a closed vs open reduction of her left hip with nailing surgery.

The findings include:

1. R6's Face Sheet, undated, documents R6 was admitted to the facility on 3/1/23, with the diagnoses of Dementia, Atrial Fibrillation, Major depressive disorder, Type 2 Diabetes Mellitus (DM), and Left femur fracture.

R6's Care Plan, dated 3/02/23, documents R6 is at risk for falls related to diagnosis of dementia, unsteadiness on feet, muscle wasting and atrophy, depression, incontinence and use of psychotropic medication. Interventions: 12/18/23: Staff to keep resident within view while in common area, 12/12/23: Occupy resident with meaningful distractions, 12/5/23: Observe frequently and place in supervised area when out of bed, 11/20/23: Encourage shoes while ambulating, 10/2/23: Encourage resident to stay in common areas when it is not bedtime. Redirect with activity, 9/6/23: Dycem replaced on wheelchair and cushion, 8/27/23: encourage resident with an activity while other residents are being put to bed, 8/14/23: PT (physical therapist)/OT (occupational therapist) to evaluate chair positioning, 8/14/23: Call don't fall signs placed in resident room, 6/26/23: Dycem applied to wheelchair and on top of wheelchair cushion, 4/20/23: Make sure resident is wearing grip socks while ambulating, 4/20/23: Grip tape applied to the floor in front of the toilet, 4/10/23: Make sure

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tennis balls are on the wheeled walker 3/2/23: Provide with wheelchair and walker, Encourage to use side rails/enablers as needed.

R6's Minimum Data Set (MDS), dated 12/6/23, documents R6 has a severe cognitive impairment and requires extensive assistance from one to two staff members for all Activities of Daily Living (ADLs). R6 is occasionally incontinent of urine and always continence of bowel.

The Facility's Fall Log, dated 6/1/23 through 12/18/23, documents R6 has had a falls on 6/21/23, 6/25/23, 7/7/23, 7/13/23, 7/20/23, 8/10/23, 8/26/23, 9/4/23, 9/25/23, 11/6/23, 12/4/23, 12/5/23, and 12/10/23.

R6's Admission Fall Risk Assessment, dated 3/1/23, documents R6 is a High Fall Risk. R6's Fall Risk Assessment, dated 4/24/23, documents R6 is a High Fall Risk. R6's Fall Risk Assessment, dated 7/29/23, documents R6 is a High Fall Risk. R6's Fall Risk Assessment, dated 12/4/23, documents R6 is a High Fall Risk.

R6's Nursing Note, dated 4/1/23 at 6:00 PM, documents, "CNA reported to nurse that resident had fallen after standing from dining room and tripped over the foot of her walker and lost her balance. CNA stated she did not hit her head. Neuros (neurological checks) and VS (vital signs) WNL (within normal limit), during assessment of LLE (left lower extremity) resident verbalized 7/10 pain to left hip. MD (Medical Doctor) made aware and gave orders to send resident to ER (emergency room) and stated to update him with results once notified of results. POA (Power of Attorney) notified as well." There is no new fall intervention seen in R6's Care Plan after her fall on 4/1/23.

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R6's Nursing Note, dated 4/3/23 at 6:51 AM, documents, "Resident found sitting on floor next to her walker in her bedroom. Residents bottom was facing the window and her legs/feet were facing the bedroom door. Resident states she was trying to go to the bathroom and her knees started to buckle so she knelt down and sit on her butt. VSS (vital signs stable) (see vitals), Head to toe assessment complete with no s/s (signs/symptoms) of rotation, deformity, shortening of limbs noted. No s/s of bruising or open wounds. Residents states, "I am ok I just wanted to get to the bathroom then go eat breakfast." Educated resident on using call light for help and she verbalized understanding. Fall was witnessed by CNA (see Event) Dr. notified, and POA Notified."

R6's Social Service Note, dated 4/10/23 at 10:25 AM, documents, "Root Cause Analysis: Investigation into falls on 4/3 and 4/1 were completed by the IDT (Interdisciplinary team). It was determined that on 4/1 resident was standing from breakfast with w/w (wheeled walker). Resident tripped over the flip flop décor on bottom of wheelchair. Décor was removed and replaced with tennis balls. On 4/3 resident was attempting to transfer herself to the bathroom with w/w when her legs buckled and she lowered herself to the floor. Assist resident in mornings, and make sure that she has assistance when needed due to weakness in morning." R6's Care Plan Intervention, dated 4/10/23, documents "Make sure tennis balls are on the wheeled walker."

R6's Nursing Note, dated 4/19/23 at 6:15 AM, documents, "[Recorded as Late Entry on 04/21/2023 11:33 AM] Called to (unit) by staff to

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find resident laying on the floor on her back with her head down by the sink. She denies pain moves all extremities without difficulty. She does have a 0.5 cm (centimeter) skin tear noted on her Rt (right) elbow that was cleansed and Steri-strips applied. Staff reports that there were no lights on in the room when they entered the room the floor was dry and resident had regular socks on her feet with no shoes on. Resident assisted off the floor by 2 staff at this time."

R6's Social Service Note, dated 4/20/23 at 11:11 AM, documents, "Root Cause Analysis: Investigation into fall on 4/19/2023 was completed by the IDT. It was determined that resident fell while ambulating in her room. Make sure the resident is wearing grip socks while up ambulating." There is no new fall intervention added to R6's Care Plan after her fall on 4/19/23.

R6's Nursing Note, dated 4/20/23 at 3:20 AM, documents, "Resident was found sitting on the floor in the her bathroom yelling out for staff. She stated she went to get off of the stool and slipped down to the floor. Denies hitting head. Stated she landed on her buttocks and sat against the bathroom door. She complained of left hip pain immediately and leg is bent up. She will not let us straighten leg out stating the pain is absolutely horrible. Large skin tear noted to left elbow with scant amount of bleeding noted."

R6's Nursing Note, dated 4/20/23 at 3:51 AM, documents, "Resident did have rubber sole shoes on, floor level dry and free of clutter. She was ambulating with use of walker. Denied any dizziness or other complications. Room was well lit."

R6's Social Service Note, dated 4/20/23 at 11:13

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AM, documents, "Root Cause Analysis: Investigation into fall on 4/20/2023 was completed by the IDT. It was determined that resident fell off the toilet while taking herself to the bathroom. Resident was sent to ER and determined that her left hip was broke. (sic) Grip tape was placed in front of toilet." R6's Care Plan Intervention, dated 4/20/23, documents, "Grip tape applied to the floor in front of the toilet." On 12/20/23 at 9:35 AM, there was no grip tape seen in front of R6's toilet as specified in the Care Plan.

R6's Nursing Note, dated 4/21/23 at 9:50 AM, documents, "Called (Regional Hospital) and rec'd (received) update on resident, surgery scheduled for today at 2:30 PM, having a closed vs open reduction of left hip with nailing, not looking at discharge until next week possibly."

R6's Nursing Note, dated 6/21/23 at 9:55 PM, documents, "Resident was observed on the floor on her knees leaning against the bed in an unoccupied room. There was another female Resident sitting on the side of the bed. This Resident stated she was trying to get on the bed. Two staff transferred Resident to w/c (wheelchair). ROM (range of motion) WNL x 4 extremities. No injuries noted to head or body. Noted both knees to have small pinkish area on each. Resident stated her knees hurt. Resident was moving both feet to move w/c without c/o (complaint of) or noted difficulty then ambulated to toilet from w/c with use of w/w and assist of two staff with no c/o or noted difficulty. Dr. at facility to see Resident and assessed her with NNO (no new orders). Tylenol given with no further c/o knee pain. Made RN (Registered Nurse) DON (Director of Nursing) and POA/daughter aware of this event. Will fax Dr. with an update. VS 134/64

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78 20 98.0 SpO2 96% RA (room air). Not compliant with Neuros." R6's Care Plan does not have any new interventions added to the Care Plan after this fall on 6/21/23.

R6's Nursing Note, dated 6/25/23 at 3:32 PM, documents, "CNA's reported that resident had slid out of wheelchair in sitting area. Resident observed sitting in upright position in front of wheelchair. Resident completed ROM to all extremities without limitations or pain voiced. Resident denies pain/discomfort at this time. Resident vs WNL, resident neuros WNL to resident baseline. MD notified and POA made aware." R6's Care Plan Intervention, dated 6/26/23, documents "Dycem applied to wheelchair and on top of w/c cushion."

R6's Nursing Note, dated 7/7/23 at 6:53 PM, documents, "Resident found on floor next to toilet. She was between the wall and toilet sitting on her buttocks holding onto the assist bar. Resident was attempting to transfer self off of the toilet. No injuries noted at this time. Denies any pain at this time. Had rubber sole shoes in place, pants were mostly pulled up chair was locked and in doorway. Daughter (Name) notified of incident. Doctor notified. Neuros started and WNL, ROM WNL. Staff educated not to leave room while she is on toilet." R6's Care Plan does not have any new interventions added to the Care Plan after this fall on 7/7/23.

R6's Nursing Note, dated 7/13/23 at 9:01 PM, documents, "Res (resident) noted to tip recliner over in the common room and rolled out of it onto the floor. When this nurse arrived, res was lying on her stomach with her Right arm pinned below her. 3 staff members rolled res over onto her back to assess further. ROM WNL. No rotation or

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shortening of extremities. VS WNL neuro checks WNL. skin tear noted to right lower arm with bruising surrounding area. Bruise noted to right elbow and to left knee. Skin tear cleansed and steri-strips applied. No other injuries noted. Res denied pain elsewhere. Assisted back to recliner. Began conversing with staff again. Continue to monitor vs with neuros per protocol. MD made aware via fax. To notify family in the morning at a more decent hour." R6's Care Plan does not have any new interventions added to the Care Plan after this fall on 7/13/23.

R6's Nursing Note, dated 7/20/23 at 10:59 PM, documents, "8:10 PM Resident was observed laying on her left side on the floor beside her bed. Her w/c (wheelchair) was near her. Resident stated she was trying to get into bed. No injuries noted to head or other areas. ROM not done d/t (due to) Resident c/o pain to both hips and lower back. BS (blood sugar) 205. Resident alert and verbal. Made Dr. aware. New order given to send to ER to eval (evaluate) and tx (treat). Made POA/daughter aware. Ambulance called. Resident sent to (local hospital) ER via ambulance. Sent Face Sheet, orders and DNR (Do Not Resuscitate). Made RN (Registered Nurse) at (local hospital) ER aware and gave report. Administrator and RN, DON aware." R6's Care Plan does not have any new interventions added to the Care Plan after this fall on 7/20/23.

R6's Nursing Note, dated 8/10/23 at 6:50 PM, documents, "Resident slid out of wheelchair trying to reach for items. Fall witnessed did not hit head and just slid to floor. She did land on her buttocks with no injuries noted and no complaints of pain. ROM WNL. Daughter notified of her sliding out of her wheelchair with no injuries. Doctor notified. Will consider adding Dyson to top of cushion to

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help prevent sliding." R6's Care Plan Intervention, dated 8/14/23, documents, "Call Don't Fall signs placed in resident room."

R6's Nursing Note, dated 8/26/23 at 8:30 PM, documents, "Resident observed on floor in kitchen laying on her right side, w/c was near her feet. Resident did hit her head. ROM WNL x 4 extremities. Resident rubbed her head stating that is where she hit her head, mid left back of head. No area noted. No other injuries noted. VS 134/70 74 20 97.6 SpO2 96% RA. Made Dr. aware of this event, Resident hitting head mid left side, Coumadin use, recent INR (International Normalized Ratio). Stated to monitor and report significant changes. Aware of HS (hours sleep) meds and stated to continue with meds as ordered. Made POA/daughter aware and she agrees with Dr. Made Administrator aware. At this time a slightly elevated area is noted to mid left back of head. Area is pinkish. Resident given PRN Tylenol d/t to stating, "Oh, it hurts a little", when asked if her head hurt. Denies pain anywhere else. Resident is alert and verbal. Moves all extremities with no noted difficulty or c/o." R6's Care Plan Intervention, dated 8/27/23: encourage resident with an activity while other residents are being put to bed.

R6's Social Service Note, dated 8/27/23 at 2:18 PM, documents, "Root Cause Analysis: Investigation into fall on 8/26/2023 was completed by the IDT team. It was determined that resident fell while attempting to ambulate. When staff is working with other residents for bed and behaviors, encourage resident with a independent activity to keep her busy."

R6's Nursing Note, dated 9/4/23 at 3:33 PM, documents, "Resident was found in dining room.

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Resident was in front of wheelchair on her left side. Resident stated she was a little sore. No shortening, ROM x 4, Neuros and vitals WNL. POA aware. Admin aware. MD faxed. Will continue to monitor." R6's Care Plan Intervention, dated 9/6/23, documents, "Dycem replaced on WC and cushion."

R6's Social Service Note, dated 9/6/23 at 7:48 PM, documents, "Root Cause analysis: IDT completed investigation into fall on 9/4/2023. It was determined resident fell sliding out of the wheelchair, Dycem added to wheelchair."

R6's Nursing Note, dated 9/25/23 at 2:02 PM, documents, "Resident stated went into her room, shut the door and got up to go the bathroom. Resident was found sitting in her room on her bottom, with feet straight out. ROM unchanged. Denies any c/o pain or discomfort. Vitals within normal limits. Dr. notified of incident. POA notified." R6's Care Plan does not have any new interventions added to the Care Plan after this fall on 9/25/23.

R6's Social Service Note, dated 10/2/23 at 12:05 PM, documents, "Root Cause Analysis: Investigation into fall on 9/25/2023 was completed by the IDT team. It was determined that resident fell while in room attempting to transfer her self. Staff encouraged to redirect resident to common areas when not in bed, and engage her with activities." R6's Care Plan Intervention, dated 10/2/23, documents, "Encourage resident to stay in common areas when it is not bedtime. Redirect with activity."

R6's Nursing Note, dated 11/6/23 at 7:45 PM, documents, "Resident was sitting in wheelchair in her room at foot of bed near bathroom door. She

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stood up and starting walking across the room. Her legs gave out and she sat down on the floor. Her feet were bare, lights on, floor level, clean, dry and free of clutter. Could not get to resident fast enough before she fell, she did not hit her head. ROM done with no complaints of pain. No external fixation or shortening of legs noted. She did complain of general pain after a while, PRN Tylenol given with relief. MD notified and daughter to be notified. Will continue to monitor." R6's Care Plan does not have any new interventions added to the Care Plan after this fall on 11/6/23.

R6's Social Service Note, dated 11/9/23 at 10:04 AM, documents, "[Recorded as Late Entry on 11/20/2023 10:05 AM] Root Cause Analysis: Investigation into fall completed by the IDT. It was determined that resident fell while attempting to ambulate to the bathroom. Resident to have shoes and grip socks on while ambulating."

R6's Nursing Note, dated 12/4/23 at 1:30 PM, documents, "[Recorded as Late Entry on 12/04/2023 07:37 PM] Resident was in common area and was trying to transfer self into recliner and slid onto bottom. Head was not hit and no injury noted. Will pass along to nurse to make Dr. and POA aware of event."

R6's Nursing Note, dated 12/5/23 at 1:50 PM, documents, "Resident attempted to transfer to recliner in common area and fell to floor. Resident did not hit her head. CNA was unable to get to her in time. B/P 159/76 P 76 R 22 T 97.5 SpO2 98% ROM WNL Resident had no c/o pain. Resident was transferred up from floor to recliner." R6's Care Plan Intervention, dated 12/5/23, documents "Observe frequently and place in supervised area when out of bed."

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R6's Nursing Note, dated 12/10/23 at 5:27 PM, documents, "CNA states she heard patient yelling out. Went to assess and patient was noted in sitting position in dining room with wheelchair next to her. Writer assess patient and she stated she did not hit her head. Patient was noted in sitting position next to wheelchair. Patient was in a well lit area and appropriate fitting shoes. Patient able to move all extremities with ease. Denies pain or discomfort at this time etc. denies needing to go to the bathroom. Assist for floor to bed via (full body mechanical lift). Neuro checks WNLs." R6's Care Plan Intervention, dated 12/12/23, documents, "Occupy resident with meaningful distractions." R6 was left unsupervised and found on the floor.

On 12/19/23 at 9:27 AM, R6 was sitting in recliner watching movie with other residents, with no staff seen in the room.

On 12/20/23 at 9:35 AM, R6 was seen sitting in her wheelchair in the dining room doing activities with staff. There were no "Call Don't Fall" signs posted in R6's room, and there was no grip tape in front of her toilet as specified in the Care Plan.

On 12/19/23 at 10:04 AM, V5, Certified Nursing Assistant (CNA), stated, "We try to keep our residents supervised to help keep them from falling, and there are interventions placed in their care plan for falls."

On 12/26/23 at 10:40 AM, V6, CNA, stated, "No, (R6) does not have a Dycem on her wheelchair."

2. R8's Face Sheet, undated, documents R8 was admitted to the facility on 3/6/23, with the diagnoses of Dementia, Overactive bladder,

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Dysuria, and Anxiety disorder.

R8's Care Plan includes Problem, start date of 7/24/23, R8 is at risk for falling related to decreased mobility, generalized weakness, dementia, incontinence, psychotropic medication use. Interventions: 9/25/23: Scoop mattress added to bed, 8/14/23: Dycem added to wheelchair, 7/24/23: Ensure that commonly used or reached for items are within close proximity to R8 while in bed, Ensure familiar items are present in room such as old pictures of resident when young, with parents, etc., familiar decorations from resident's prior home, or familiar afghan/blanket on bed, Use simple sentences with ADL (Activities of Daily Living) cares including nouns and verbs only (example: Use the toilet), Utilize verbal and tactile cues. Organize supplies from left to right to provide visual stimulation with tasks and task segmentation, Use simple, familiar commands and words that are familiar to the resident (i.e. john = bathroom), Hold chair steady for R8 during transfers, Provide frequent reminders and assistance for toileting and other personal care ADL needs, Alternate Call Light, Encourage R8 to use side rails and hand rails as needed.

The Facility's Fall Log, dated 6/1/23 through 12/18/23, documents R8 had falls on 6/1/23, 6/16/23, 8/11/23, and on 9/16/23. R8's Clinical Record documents R8 also had falls 3/14/23, 3/25/23, 4/2/23, 5/3/23, 5/12/23, 5/16/23, 5/17/23. R8's Care Plan did not include R8 as a fall risk with interventions until 7/24/23, after R8 had fallen nine times.

R8's MDS, dated 12/6/23, documents R8 has a severe cognitive impairment and is dependent on staff for ADLs and is frequently incontinent of

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urine and occasionally incontinent of bowels.

On 12/19/23 at 10:04 AM, V5, CNA, stated, "We try to keep our residents supervised to help keep them from falling and there are interventions placed in their care plan for falls."

R8's Nursing Note, dated 3/14/23, documents, "Resident was found on floor in bed room next to his bed on his bottom. Residents back was against the bed, feet pointing to his roommates bed and resident was not in non skid socks at that present time. Resident states he slid out of bed on his bottom trying to get somewhere. Head to toe assessment completed. No apparent injuries noted. No bruising noted. No wounds or bleeding noted. No limb deformity noted. Mobility unaffected. Did c/o pain to right hip but per resident and resident POA he has prior hip surgery and has had hip pain to left hip since. Resident able to bend bilateral knees to abdomen without c/o, able to rotate and flex bilateral arms without c/o. NEURO intact (neuros started due to unwitnessed fall) Bed was at lowest position and call light was within reach."

R8's Administrator Note, dated 3/19/23 at 2:43 PM, documents, "Root Cause Analysis: Investigation into fall on 3/14/2023 completed by IDT (Intradisciplinary team). It was found that resident was trying to transfer himself without assistance, and fell from bed. Call don't fall signs places in residents room to remind him to call for assistance." On 12/20/23 at 9:32 AM, there was no "Call don't fall" signs seen in R8's room.

R8's Administrator Note, dated 3/28/23 at 2:13 PM, documents, "Root Cause Analysis: Investigation into fall on 3/25/2023 completed by IDT. It was determined resident was trying to

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stand without assistance. Make sure resident is in a supervised area, and wearing slip resistant socks."

R8's Nursing Note, dated 4/2/23 at 9:29 AM, documents, "Resident observed on floor facing in upright position in front of toilet. Resident voiced that he was trying to go to the bathroom and slid off of the toilet. No injuries noted. VS WNL, Neuro assessment completed with no abnormalities noted to resident baseline. ROM completed x 4 extremities without pain/discomfort. Resident denies pain at this time. MD notified, POA notified."

R8's Social Service Note, dated 4/10/23 at 12:06 PM, documents, "Root Cause Analysis: Investigation into fall on 4/2/2023 was completed by the IDT team. It was determined that the resident was attempting to transfer himself to the bathroom. staff educated to ask resident frequently if he needs to use the bathroom in hopes to avoid resident attempting to transfer himself."

R8's Nursing Note, dated 5/3/23 at 2:48 PM, documents, "Resident observed sliding from wheelchair while trying to self transfer to bed. Resident non skid socks were on, but one was turned where grippers were not in correct position. No injury noted. VSS. No c/o pain voiced. POA aware. MD notified via faxed."

R8's Nursing Note, dated 5/11/23, documents, "Root cause analysis: resident was attempting to transfer self and slid out of wheelchair. Resident noted to be wearing gripper socks inappropriately. Resident to wear slippers with rubber soles or shoes when up in chair. Care plan updated."

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R8's Nursing Note, dated 5/12/23 at 8:50 PM, documents, "[Recorded as Late Entry on 5/13/2023 1:32 AM] Resident was assisted to the floor by staff. He has slumped down so far in his wheelchair his back was the only thing still in the chair. Resident was assisted to the floor by CNA before he tumbled out on his own. Staff was called to assist resident back up in wheelchair. Resident had been readjusted several times in wheelchair prior to this because he keep sliding down. No injuries noted. Doctor notified. Family will be notified. Will continue to monitor."

R8's Nursing Note, dated 5/16/23 at 6:53 AM, documents, "Resident was found on floor in his room. Back against the wall and stated he hit his head. No bumps noted. Resident was trying to transfer self and was reaching for shoes. Area was free of clutter and floor was dry. Resident states he "should have known better." Educated resident on using call light and waiting for assistance. Resident did receive skin tear to left tricep 10 cm by 2 cm. Cleansed with wound cleanser and non-adherent pad applied and gauzed wrapped. Did use steri-strips to place some skin back together. Red mark to right shoulder. Vital signs are 97%, 98.3, 162/94, 78, 12. Does complain of head pain. Neuros are WNL. ROM x4. MD faxed. POA aware. DON (Director of Nursing) notified. Will continue to monitor."

R8's Nursing Note, dated 5/17/23 at 8:29 AM, documents, "Resident observed on common room area floor, reported by CNA. Resident sitting upright facing tv with wheelchair facing residents right side. Blocks noted to left side of resident on floor. BLE noted equal, ROM to X4 extremities without limitations. Resident denies pain/discomfort. Edema continues to BLE. MD

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made aware."

R8's Nursing Note, dated 6/1/23 at 4:05 PM, documents, "Resident had witness fall with no injury. ROM (range of motion) WNL (within normal limits). V/S (vital signs) WNL. Did not hit head. Assist x 2 and gait belt back to w/c (wheelchair). Son and MD made aware."

R8's Nursing Note, dated 6/16/23 at 11:14 PM, documents, "Resident observed on floor in BR (bathroom) at 7:30 pm. Resident stated he "had to go" and attempted to transfer self from w/c to toilet. Noted moderate amount of urine on floor near toilet that was not from Resident. Resident stated he hit his head possibly on the door or floor, touching the top left side of head. No noticeable injury. Resident was sitting on his buttocks slightly leaned to right side with right arm holding him up. ROM x 4 with no shortening or rotation noted. Resident did initially c/o right leg pain when he extended the right leg but was able to bend leg and pull it toward him several times with no c/o or noted difficulty. (Name) RN DON (Director of Nursing) also assessed. With assist of three Resident was transferred to his w/c with no c/o pain or discomfort. Resident then used by feet to move around in w/c without c/o pain or noted difficulty. Noted a 2 cm s/t to top of right hand. Area cleansed. Two steri-strips applied. VS 122/74 74 18 98.0 SpO2 94% RA. Made on call (Name) AGNP (Adult-gerontolgy nurse practitioner) aware and of Resident's initial c/o right leg pain. NNO. Stated to monitor and report significant changes. Made POA/son (Name) aware. Resident later c/o of low back pain then denied stating, "I guess I'll be sore by morning". Neuros continue to be WNL."

R8's Nursing Note, dated 8/11/23 at 12:18 PM,

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documents, "Resident slid out of wheelchair onto his buttocks in dining area during lunch. Fall was witnessed by unit coordinator and 2 CNA staff. No injury noted. ROM WNL for resident. No c/o pain voiced. Neuro WNL for resident. Resident assisted to bathroom per request. MD notified via fax. LM for POA. Awaiting return call."

R8's Social Service Note, dated 8/14/23 at 3:11 PM, documents, "Root Cause Analysis: Investigation into fall on 8/11/2023 was completed by the IDT team. It was determined that resident slid out of chair while repositioning himself. Dycem added to wheelchair." R8's Care Plan and Intervention, dated 8/14/23, documents "Dycem added to wheelchair." On 12/20/23 at 9:32 AM, there was no Dycem to R8's wheelchair seen.

R8's Nursing Note, dated 9/16/23 at 12:57 AM, documents, "Res rolled out of bed ROM WNL, neuro check started, no pain voiced."

R8's Social Service Note, dated 9/25/23 at 9:55 AM, documents, "Root cause Analysis: Investigation into fall on 9/16/2023 completed by the IDT. It was determined resident rolled out of bed. Scoop mattress was added to bed for residents safety." R8's Care Plan and Intervention, dated 9/25/23, documents "Scoop mattress added to bed."

3. R10's Face Sheet, undated, documents R10 was admitted to the facility on 4/17/20, with diagnoses of Cerebral infarction, Hemiplegia, Dementia, COVID-19, UTI, Osteoporosis, long term use of Anticoagulants, DVT, and Right hip fracture.

R10's Care Plan, dated 11/21/23, documents R10 is at risk for falling r/t generalized weakness, high

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fall risk medications, pain, dx of OA, hemiplegia, muscle wasting and atrophy, abnormal posture, HTN, and anemia. Interventions: Give resident verbal reminders not to ambulate/transfer without assistance, Grip strips to floor in front of recliner, place call don't fall signs in resident room and on walker and wheelchair, re-educate to call for assistance, Encourage R10 to use environmental devices such as hand grips, hand rails, etc., Therapy to educate Staff on proper transfer technique. It continues R10 requires assistance with her everyday ADLs r/t a diagnosis of dementia. Interventions: Remind R10 the importance of eating, Offer food she likes, easy food to chew, Offer to open packages, cut her food for her, Lay her supplies out left to right, Offer toothpaste within 6 inches of eye level.

R10's MDS, dated 11/13/23, documents R10 has a severe cognitive impairment and requires extensive assistance from one or two staff members for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing, and requires supervision with set up help for eating. R10 is always incontinent of both bowel and bladder.

The Facility's Fall Log, dated 6/1/23 through 12/18/23, documents R10 had a fall on 6/9/23, and 10/2/23.

R10's Nursing Note, dated 4/30/23 at 8:25 PM, documents, "Res slid out of wheel chair d/t leaning forward to pick up a piece of food off floor, no injuries ROM WNL, no pain voiced."

R10's Nursing Note, dated 6/9/23 at 4:24 PM, documents, "Resident observed on floor in room sitting in upright position, wheelchair facing in front of resident. Resident denies pain/discomfort.

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ROM x all extremities without limitations. POA made aware, md notified. VS and neuros WNL."

R10's Nursing Note, dated 10/2/23 at 5:35 PM, documents, "MD aware of fall and states monitor and report significant changes."

R10's Nursing Note, dated 10/3/23 at 9:59 AM, documents, "No injuries noted from fall. Will continue to monitor."

R10's Social Service Note, dated 10/4/23 at 5:51 PM, documents, "Root Cause analysis: Investigation into fall on 10/2 completed by the IDT. It was determined that resident slid from bed, while attempting to transfer. Resident encouraged to call for assistance before attempting to self transfer."

On 12/18/23 at 10: 20 AM, R10 was seen sitting in a recliner in living area, napping, covered with blanket, with her wheelchair next to recliner, and no staff present in the living area.

On 12/19/23 at 9:27 AM, R10 was sitting in a recliner watching movie with other residents with no staff present in the room.

On 12/19/23 at 10:04 AM, V5, CNA, stated, "We try to keep our residents supervised to help keep them from falling and there are interventions placed in their care plan for falls."

On 12/20/23 at 9:38 AM, R10's fall interventions, according to his Care plan, include verbal reminders not to ambulate without assistance, grip strips to floor in front of recliner, call don't fall signs in room, on her walker and wheelchair. R10 resting in recliner in living area, there is no sign on her walker/wheelchair, no signs posted in

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her room, there are no grip strips in front of her recliner, and no staff members seen.

4. R27's Face Sheet, undated, documents R27 was admitted to the facility on 4/22/23, with the diagnoses of Dementia, Falls, Anxiety disorder, and Blindness both eyes.

R27's Care Plan, dated 4/25/23, documents R27 is at risk for falls related to diagnosis of dementia, blindness, weakness, use of psychotropic medication, and incontinence. Interventions: 12/18/23: Observe frequently, and place in supervised area when out of bed, 12/10/23: Provide toileting assistance every 2 hours and PRN (as needed), 5/18/23: Enhanced supervision in the dining room; reminders to wait for staff assist with ambulation, Instruct resident to call for assist before getting out of bed or transferring. 4/25/23: Instruct resident to call for assist before getting out of bed or transferring. Encourage resident to stand slowly, Encourage resident to use side rails/enablers as needed. It continues R27 has impaired vision related to blindness right/left eye. Interventions: Orient resident when there has been new furniture placement or other changes in environment, Assure the floor is free of glare, liquids, foreign objects, Keep call light in reach at all times, Provide resident an environment free of clutter, Provide verbal cues and orient to the location of self care items to enhance independence.

R27's Minimum Data Set (MDS), dated 10/25/23, documents R27 has a severe cognitive impairment and requires extensive assistance from one staff member for his ADLs. R27 is occasionally incontinent of urine and always continent of bowel.

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The Facility's Fall Log, dated from 6/1/23 through 12/18/23, documents R27 has had a fall on 10/24/23, 12/10/23, and 12/15/23.

R27's Admission Fall Risk Assessment, dated 4/25/23, documents R27 is a High Fall Risk. There are no other Fall Risk Assessments completed in R27's medical record.

R27's Nursing Note, dated 5/17/23 at 8:55 AM, documents, "Resident observed on floor in dining room next to dining room table sitting upright. ROM (Range of Motion) assessed x all 4 extremities without limitations or complaints of pain with ROM but did state he bumped his right shoulder. Surrounding area of resident free of clutter. Resident stated 'Went to get up and went down.' MD (Medical Doctor) and POA (Power of Attorney) made aware."R27's Care Plan Intervention, dated 5/18/23: Enhanced supervision in the dining room; reminders to wait for staff assist with ambulation, Instruct resident to call for assist before getting out of bed or transferring.

R27's Nursing Note, dated 10/25/23 at 12:06 AM, documents, "CNA reported Resident was sitting upright on the floor in his room. When this writer arrived Resident observed sitting on bed by window. Resident denied being on the floor, denied hitting his head, and denied pain or discomfort. Resident refused ROM but it was noted that Resident moved all extremities and ambulated with no noted difficulty or c/o (complaints of). No injuries noted to head or other visible areas on body. Resident refused neuros at the time and since. Made POA/wife aware. Made Administrator aware. Will make Dr. aware." There was no new Interventions updated in R27's Care Plan after the fall on 10/25/23.

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R27's Nursing Note, dated 12/10/23 at 6:55 AM, documents, "CNA was walking past patient room and noted him on floor in bedroom. Writer noted patient in right side lying position in front of bathroom door with the wheelchair on his left side. Patient not able to verbalize what he was doing. No injuries noted and patient able to move all extremities with ease. Patient did have on proper fitting shoes. Call light was in place and not on. Neuro checks started and WNLS (within normal limits). MD and POA notified of incident."

R27's Nursing Note, dated 12/11/23 at 11:04 AM, documents, "N.O. (new order) for PT (Physical Therapy) to evaluate and treat for increased fall risk."

R27's Nursing Note, dated 12/15/23 at 5:27 PM, documents, "Resident was sitting in his recliner and decided to get up and walk to the door, which resident is blind and doesn't walk, so he fell at the door hitting his head on the right side behind his ear on the door frame, no open area and no bruising or knots noted and he stated that his right ankle was hurting, it is slightly swollen and bruised on the lateral side, I iced it and elevated it and his right shoulder was hurting. (Company) was called for x-ray's."

On 12/18/23 at 10:27 AM, R27 was seen sitting in his recliner with a hospital bracelet on, and when asked if he was in hospital recently, R27 stated he went to the hospital after he fell at the facility. R27 stated he cannot walk by himself, and the staff will help him with walker or wheelchair.

On 12/19/23 at 9:27 AM, R27 was sitting in a recliner watching movie with other residents, with no staff supervision seen.

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On 12/19/23 at 10:04 AM, V5, Certified Nursing Assistant (CNA), stated, "We try to keep our residents supervised to help keep them from falling, and there are interventions placed in their care plan for falls."

On 12/19/23 at 11:12 AM, V19, R27's Daughter, visiting with R27 in living area. V19 stated, "Dad is blind in both eyes and has fallen while trying to get up by himself, when he doesn't think anyone is around to help."

On 12/21/23 at 9:08 AM, V9, CNA, stated, "I'm not sure what enhanced supervision means. I would think that means that we check on the resident maybe every 15 minutes or so, or walk up and down the hall while they are in their room."

On 12/21/23 at 9:25 AM, V5, CNA/Director of Memory Care, stated, "Enhance Supervision means that we should have constant supervision on a resident. The staff should have constant eyes on the resident, and the resident should be in the line of sight at all times."

On 12/21/23, from 9:00 AM, until 9:15 AM, R27 was seen sitting at a dining room table by himself, unsupervised, with no staff member seen.

On 12/26/23 at 11:53 AM, V1, Administrator, stated, "We do not have a Fall Prevention policy. I'm always told to just give you this (Emergencies policy), and I highlighted on page two about how to handle falls after they happened."

The Facility's "Emergencies" Policy, dated 4/3/18, documents "A. Falls: 1. Check the resident immediately for ability to move extremities; check

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for bruised areas and/or cuts. 2. Check resident's ability to explain what happened; evaluate resident's condition before the fall. 3. Check if or with anyone who witnessed the accident. Determine, if possible, where, how, and when the accident occurred. 4. Check for any apparent dislocation or possible fracture. 5. Exercise special care in transferring the resident. 6. Call the resident's physician. 7. If head injury has occurred with loss of consciousness, notify physician immediately for orders to transfer to emergency room. 8. If head injury has occurred, notify physician and monitor vital signs and neuro checks at least every four hours for twenty-four hours. 9. If a fall is witnessed, notify physician and initiate neuro checks at least every four hours for twenty-four hours."

The Facility's "Safe Resident Handling" Policy, dated 11/2012, documents "Facility is dedicated to providing quality care to residents who have entrusted their lives to us, and to provide a work environment that is safe and enjoyable to staff. Our safe resident handling program is designed to meet the following goals: Protect staff and residents from injury. Procedure: 1. All residents will be assessed for safe resident handling and moving. 5. All staff members required to use the lifting devices will be oriented and trained on the proper use. Each staff member will have first-hand experience on what the lift feels like from a resident perspective. Staff is to report any concerns about transfers that may pose an unacceptable risk for injury to a resident or staff to DON. Resident will then be reassessed for safe procedures. When using full mechanical lift or sit-to-stand mechanical lift, two staff members are used with additional help as needed. When using the stand aide/ultra move (non-mechanical standing device) one staff member is used with

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additional assist as needed. If care planned with two assist it must be used with two staff members. 9. When physically transferring residents, gait belts will be used to maintain appropriate transfer techniques.

5. R20's Care Plan, dated 4/12/23, documents Problem: (R20) is at risk for falling R/T decreased mobility, Diagnosis of diabetes mellitus, peripheral vascular disease, chronic kidney disease, congestive heart failure, use of diuretic medication, use of anti-depressant medication, hypertension, hyperlipidemia, chronic obstructive pulmonary disease, chronic respiratory failure, and anemia. history of stroke, left side above the knee amputation. Approach: Full mechanical lift and two staff for transfers.

R20's MDS, dated 10/25/2023, documents R20 is severely cognitively impaired and dependent of staff to transfer from bed to chair.

On 12/18/23 at 11:10AM, V10, CNA, and V11, CNA, assisted R20 with a transfer from R20's bed to wheelchair. V10 and V11 applied the sling straps to the lift. V10, working the controls, lifted R20 up over the bed. V10 then pulled R20 from over the bed, across the room to the wheelchair and allowing R20 to swing in the sling. V11 standing behind the wheelchair grabbed a hold of the sling as V10 was lowering R20 into the wheelchair. V10 and V11 did not check the hooks to assure they were safe.

On 12/21/2023 at 12:10 PM, V2 (Director of Nursing) stated she expects the staff to inspect the sling before each use. V2 stated mechanical transfers are a 2 staff process. V2 stated 1 staff works the controls and the other staff would have hands on the resident at all times, and would not

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allow the resident to swing in the sling during the transfer.

The facility's Safe Resident Handling policy, dated 11/12, documents this program is designed to Maintain a high level of resident dignity and quality care and protect staff and residents from injury. It also documents that When using Full Mechanical Lift 2 staff members are used with additional help if needed. If care planned with 2 assist it must be 2 assist.

(A)

2 of 2

300.610 a)
300.696 a)
300.696 b)3)
300.696 d)6)
300.696 f)2)A)
300.1210 b)

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 300.696 Infection Prevention and Control

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S9999	Continued From page 28 a) A facility shall have an infection prevention and control program for the surveillance, investigation, prevention, and control of healthcare-associated infections and other infectious diseases. The program shall be under the management of the facility ' s infection preventionist who is qualified through education, training, experience, or certification in infection prevention and control. b) Written policies and procedures for surveillance, investigation, prevention, and control of infectious agents and healthcare-associated infections in the facility shall be established and followed, including for the appropriate use of personal protective equipment as provided in the Centers for Disease Control and Prevention ' s Guideline for Isolation Precautions, Hospital Respiratory Protection Program Toolkit, and the Occupational Safety and Health Administration ' s Respiratory Protection Guidance. The policies and procedures must be consistent with and include the requirements of the Control of Communicable Diseases Code, and the Control of Sexually Transmissible Infections Code. 3) Facility activities shall be monitored on an ongoing basis by the Infection Preventionist to ensure adherence to all infection prevention and control policies and procedures d) Each facility shall adhere to the following guidelines and toolkits of the Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, Agency for Healthcare Research and Quality, and Occupational Safety and Health Administration (see Section 300.340): 6) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings f) Infectious Disease Surveillance Testing and Outbreak Response	S9999		

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2) Each facility shall conduct testing of residents and staff for the control or detection of infectious diseases when:

A) The facility is experiencing an outbreak

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement a system to track and trend infections, and failed to implement infection control procedures including isolation precautions and personal protective equipment (PPE) to prevent the spread of infection. These failures resulted in 23 residents devloping Gastroenteritis, including 8 residents (R10, R29, R32, R37, R41, R52, R56, R160) currently experiencing Gastroenteritis in the facility. These failures have the potential to affect all 58 residents in the facility.

Findings include:

The employee call off log documented on 11/27/23, V22, Dietary Aide, called off work because of Gastrointestinal symptoms. Subsequently, from 11/27/23 to 12/15/23, 23 staff developed Gastroenteritis.

The facility's Infection Control Tracking documented on 12/3/23, R56 developed Gastroenteritis symptoms, and no isolation precautions were implemented. From 12/3/23 to 12/21/23, 23 additional residents developed Gastroenteritis including R5, R7, R9, R10, R16, R20, R23, R25, R28, R29, R30, R31, R32, R37, R41, R44, R45, R50, R52, R54, R56, R111, R160. During the survey, R10, R29, R32, R37, R41, R56, R160 were experiencing

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gastroenteritis.

On 12/18/23 through 12/21/23, there was no signage on the doors indicating any of the residents were on contact isolation.

R32's Nurse's Note, dated 12/10/2023 at 9:28 PM, documents, "7pm Resident's urine is dark. Decreased urine output. States she has not drank much fluids today d/t (due to) it upsets her stomach. VS (Vital Signs) 134/68 (blood pressure) 74 (pulse) 20 (respiration) 97.0 (temperature) SpO2 (oxygenation saturation) 95% RA (room air). Made on call (V61, Nurse Practitioner, NP)) aware. Gave order for Saline IV 1 L (liter) at 75 ml (milliliter) per hour and Zofran (nausea medication) 4 mg (milligram) every one tab every four hours for n/v (nausea/ vomiting)."

R32's Nurse's Note, dated 12/11/2023 at 12:29 AM, documents, "IV continues. Resident was incontinent of a large loose stool at 9 pm. Resident given PRN (as needed) Zofran at 7:15 pm for c/o (complaint of) nausea. Urine color improving. Resident has drank a little water."

R32's Nurse's Note, dated 12/11/2023 at 2:39 AM, documents, "Linens changed after earlier incontinent loose stool."

R32's Nurses Note, dated 12/11/2023 at 11:16 PM, documents, "Resident BS (blood sugar) 552 at HS (hour of sleep). Emesis x 1, milk with pieces of mandarin oranges. Zofran given. Made (V62, NP) aware. Stated to continue with sliding scale as ordered for BS (blood sugar) over 400. Monitor and report. Also made aware of emesis, recent IV fluids, and loose stools. Novolog sliding scale given as ordered. Will monitor."

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R32's Nurse's Note, dated 12/11/2023 at 11:19 PM, documents,"10:30 pm Emesis x one. Resident diet 7-Up given with effectiveness."

R32's Nurse's Note, dated 12/12/2023 at 10:13 AM, documents, "Resident noted to have elevated blood glucose at 556 this AM. while still refusing to eat. Insulin given and MD (Medical Doctor) notified, rechecked after 30 minutes and blood glucose was 507. Resident continues to feel nauseous and refusing to eat. MD stated to send out to ER (Emergency Room) for evaluation r/t (related to) elevated blood glucose. POA (Power of Attorney) aware of sending out to ER for evaluation."

R32's Nurse's Note, dated 12/12/2023 at 03:32 PM, documents, "Resident back from ER visit. No new orders at this time. Resident received IV fluids and insulin in ER. Encourage fluids and monitor blood glucose."

R32's Nurse's Note, dated 12/13/2023 at 9:41 AM, documents, "Resident states she is feeling just a little better today. Zofran given for nausea. AM blood glucose was low at 56, gave large glass of juice and she ate her breakfast sausage, rechecked and it was 119. Continued to encourage to increase fluids at this time."

R32's Nurse's Note, dated 12/16/2023 at 2:05 AM, documents, "Resident c/o (complaint of) nausea at HS (hour of sleep/bedtime). Gave PRN Zofran with effectiveness. HS BS 92. Offered snack but Resident stated, 'I don't need it'. Resident encouraged to eat and drink fluids. Covid test: negative."

R32's Nurse's Note, dated 12/16/2023 at 11:35 AM, documents, "Resident states that she still

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does not feel well and does not feel like getting up out of bed at this time, she is very nauseous, so Zofran was given at this time."

R32's Nurse's Note, dated 12/18/2023 at 1:58AM, documents, "Resident continues to feel nauseated and achy, refused her meds and meals. Requested ice water only. (Indwelling urinary catheter) patent, Tylenol given prn as ordered. MD aware and has given orders to monitor blood Glucose closely."

R32's Nurse's Note, dated 12/19/2023 at 10:57 AM, documents, "Fax sent to MD regarding resident, she has a 102.2 fever, and diarrhea. PRN Tylenol given. awaiting response from MD."

R32's Nurse's Note, dated 12/19/2023 at 03:04 PM, documents, "Labs received and Potassium is 5.2 and sodium is 129. Call placed to (V62) with results. (V62) states to send resident to ER. Ambulance called and arrived to facility within minutes. Resident does express she wants to go. Resident is a diabetic and is not well controlled. Resident continues with diarrhea and fever despite Tylenol. Urine is dark yellow draining per catheter. Resident is heading to ER now."

R32's Nurse's Note, dated 12/19/23 at 6:22 PM, documents, "Spoke to (Local Hospital) who reported that resident is being transferred to (Regional Hospital). Only dx (diagnosis) at this time: Hyperglycemia."

On 12/19/23 at 10:50 AM, R32's room was entered with V8, Licensed Practical Nurse, LPN, to administer Acetaminophen for a fever of 102.5 degrees. R32 was being cleaned up of an incontinent episode of diarrhea. R32's room had an extreme foul odor related to the stool. There

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was not an isolation cart containing personal protective equipment or isolation precaution signage outside of R32's room.

On 12/19/23 at 10:40 AM, V8 stated R32 has had loose stool and nausea for the last 3 weeks, and the doctor is aware.

R16's Nurse's Note, dated 12/09/2023 at 9:25 PM, documents, "Called to room at this time, resident having another emesis. T (Temperature) 98.1 P (Pulse) 120 R (Respirations) 20 BP (Blood Pressure) 178/97 O2 (Oxygenation) 92 @ 2L(Liters). Call made to on call dr. for (V42) at this time. On call doctor recommended resident to go to (Local Hospital) to get fluids. Call then made to make POA aware and she agreed to have resident taken to ER for evaluation and treatment. 911 called at 9:30pm."

R16's Nurse's Note, dated 12/10/2023 at 12:20 AM, documents, "Call received at this time from (Local Hospital) in regard to resident being sent back to facility. Stated hospital nurse gave resident fluids and Zofran. All testing came back negative. Resident diagnosed with Gastroenteritis. Order received for Zofran 4mg q (every) 4-6hr per rectum if unable to take orally PRN."

R16's Nurse's Note, dated 12/22/2023 at 3:47 PM, documents, "CNA notified writer that resident has had an episode of diarrhea, isolation has been started. No fever at this time. resident has no complaints at this time. POA aware, administrator aware, MD was faxed to notify."

The Gastrointestinal Log, dated 12/2023, documents R16 began to have emesis on 12/9/23, and was not put on isolation when

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symptoms of gastroenteritis began.

R41's Nurse's Note, dated 12/06/2023 at 11:56 PM, documents, "11:30 pm Moderate amount of loose stool x 1. VS 138/64 74 20 97.1 SpO2 97% RA. Covid test negative. Resident given clear soda. PRN Imodium given. Resident given Tylenol at HS med pass for c/o general discomfort. Will make (V15, Medical Director) aware."

R41's Nurse's Note, dated 12/07/2023 10:52 PM, documents, "NA (Nurse Aide) reported that she had an episode of vomiting, temperature is 99.5."

R41's Nurse's Note, dated 12/11/2023 at 1:49 AM, documents, "Two loose stools x two with PRN Imodium. Fluids encouraged. No emesis or c/o nausea. T 97.6. No c/o voiced."

R41's Nurse's Note, dated 12/16/2023 at 12:14 AM, documents, "Resident's Imodium 2 mg one tab after every loose stool with a max of three times/day continues as needed per (V15), is aware of numerous loose stools with foul odor and is also aware of coccyx being red and irritated with barrier cream being applied. Notes: monitor and report significant changes."

The Gastrointestinal Log, dated 12/2023, documents R41 began to have nausea and diarrhea on 12/7/23, and was not put on isolation.

On 12/20/23 at 1:58 PM, V6, Certified Nurse Assistant (CNA), stated, "(R41) had diarrhea yesterday. She hasn't had any today." V6 stated the (GI bug) went on for "about 2 weeks."

On 12/20/23 at 2:08 PM, V18, LPN, stated R56 had GI issues recently.

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S9999	Continued From page 35 On 12/20/23 at 12:10 PM, V16, Dietary Manager, stated, "I am the only one (of kitchen staff) that has not had the GI bug. Employees that were sick needed to be symptom free for 24 hours with a doctor's note before they came back." On 12/21/23 at 9:10 AM, V27, Cook, stated he did have Gastrointestinal symptoms and he needed to stay home for 24 hours after he was symptom free. On 12/20/23 at 10:15 AM, V14, Infection Preventionist, was questioned about the " GI (Gastro-Intestinal) Bug" that has been in the building, V14 stated, "I can't figure it out. I don't know where it is coming from. We have had to give some IV (Intravenous Fluids). The doctor did not want any testing done. I have not contacted the County Health Department because I don't know how. (V1, Administrator) is the one who calls them." V14 stated she is tracking the GI issues in the facility. The November and December Monthly Antibiotic Control log was reviewed at this time. This log failed to document any GI issues. A copy of V14's tracking was requested at this time. On 12/20/23 at 2:20 PM, V14 stated the facility does not have any residents that are currently having symptoms of nausea, vomiting or diarrhea. V14 stated, "The last resident was (R32) and she went to the hospital yesterday (12/19/23), so there are no current residents. It started around the 5th (12/5/23), the main part was the 8th through the 11th (12/8/23 - 12/11/23)." V14 stated the two residents that needed IV fluids while having GI symptoms were (R32) and (R41) (R41 did not require fluids). V14 stated R32 needed fluids twice.	S9999		

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S9999	Continued From page 36 On 12/21/23 at 10:15 AM, V14 stated, "Employees who contracted the GI bug had to be symptom free for 24 hours before returning to work." On 12/20/23 at 10:28 AM, V1, stated, "I did not report to the County Department of Health. It was not the flu (Influenza Virus), RSV (Respiratory Syncytial Virus) or COVID. The doctor was not ordering any tests. Why would I?" V1 was asked if she had considered the Norovirus, V1 stated, "No." On 12/21/23 at 10:00 AM, V1 stated, "When the residents were experiencing nausea, vomiting, or diarrhea the residents stayed in their room until they were symptom free for 24 hours. The staff wore masks because we were on COVID precautions, they wore gloves and used frequent hand washing. We did not require gowns while caring for the residents or put isolation signs or carts outside of room. At this time, we do not have any current cases. We had 2 residents receive IV fluids (R32 and R41) (R41 did not require IV fluids) and 2 residents were sent to the hospital because of it (R32 and R16). We do not have a specific GI policy and procedure. We use the basic infection control policy." On 12/21/23 at 12:00 PM, V2, Director of Nursing, (DON), stated, "If a resident was having symptoms, they had to be in the room for 24 hours until they were symptom free. We did COVID tests and notified their primary care provider. Once notified, they (doctors) just said to monitor. We did not have any specific isolation just general isolation. The doctors never gave an order regarding the type of isolation or for isolation. We did in-service for hand washing.	S9999		

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Employees that were ill stayed home until they were symptom free."

On 12/20/23 at 1:45 PM, V20, Local Health Department Registered Nurse, stated, "I was not aware that (the facility) was having an outbreak of Gastroenteritis. I would have expected them to notify us. I would have contacted them to see if they needed anything from us. I would have told them to pull the guidance from the IDPH (Illinois Department of Public Health) website, do they need help understanding it? I would expect contact isolation to be put in place, PPE (Personal Protective Equipment) by doors, signage on doors, testing of the stool to determine what bug is going around."

On 12/19/23 at 10:17 AM, R29 was on the toilet requesting assistance, as she had large amount of loose stool, both in her brief and in the toilet. V6, Certified Nursing Assistant (CNA), entered to assist R29. R29 was attempting to clean herself up, however, had stool all over herself, including her hands. V6 unfastened R29's brief and tucked it between her legs. R29's pants were wet and soiled with loose stool, and were removed by V6. After V6 gathered the soiled pants and brief to put in a plastic bag, V6 went to a dresser drawer in R29's room to gather more supplies with the same soiled gloves on. V6 then applied a gait belt around R29, a clean brief and pants on her lower legs, all with the same soiled gloves on. V6 assisted R29 to stand up and hold onto her walker while V6 wiped stool off R29's back, buttocks, and anal area. V6 reached between R29's legs and wiped from front to back with a lot of stool seen on the cloths/wipes, one dry washcloth used to reach between R29's legs once more, then brief and pants pulled up with same soiled gloves on. R29's shirt had stool on

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the bottom of the shirt, which was pulled down over her clean pants, while V6 stated she had to change her shirt because it had stool on it.

The Gastrointestinal Log, dated 12/2023, fails to document R29 having symptoms of diarrhea.

On 12/18/23 at 10:20 AM, R10 was sitting in a recliner in the living area, napping, covered with blanket, wheelchair next to the recliner, and no staff present.

On 12/18/23 at 12:55 PM, R10 was assisted back to her bed, with a strong smell of urine and feces. V7, CNA, came in to do peri-care on R10. R10's pants were pulled down which showed loose stool in her pants. R10's brief was unfastened and tucked between her legs. V7 wiped R10's groins once each, then using same wipe, wiped once down middle of her vagina, and pushed that wipe between R10's legs. As R10 was rolled over, V7 noticed loose stool was up R10's back and all over her buttocks. V7 began wiping R10's stool and asked to get another CNA to assist her. V7 used soiled gloves and pulled the sheet over R10 while she waited for help. V6, CNA, entered to assist and wiped R10's groins once, used same cloth and wiped R10's vagina once. R10 was rolled to her right side and V7 began to wipe R10's back, and anal area. Using the same gloves, V7 put a new incontinent brief and bed pad down, then applied barrier cream to R10's anal area. R10 started to have more diarrhea and was allowed to finish her bowel movement (BM). Both CNAs doffed their gloves, gathered soiled linen and trash bags without gloves on, then left the room without doing hand hygiene.

On 12/18/23 at 1:18 PM, V6 and V7 went back into R10's room to clean her up after her bowel

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movement. R10's brief was tucked between her legs. R10 was rolled to her right side and her anal area was briefly wiped, and her soiled incontinence brief was pulled out from under her. Using the same soiled gloves, V7 applied a new incontinence brief and bed pad to the bed. There was no further wiping of R10's vagina, groins, or buttocks after her BM. V7 used same soiled gloves to pull resident up in bed. V7 doffed her gloves, covered R10, then exited the room without hand hygiene done.

The Gastrointestinal Log, dated 12/2023, documents R10 as having diarrhea beginning on 12/5/23, and R10 was not put on isolation.

On 12/21/2023 at 9:25 AM, R160 stated she was having diarrhea. R160 stated she feels weak and sick to her stomach.

On 12/21/2023 at 9:40 AM, R37 stated she has had diarrhea for the last couple of days. R37 stated she has told the staff. R37 stated she has not been on any isolation precautions.

On 12/21/2023 at 9:23 AM, R56 stated she has had diarrhea yesterday and today. R56 stated she just goes in the toilet and flushes.

On 12/21/2023 at 9:33 AM, R52 stated she is nauseated and unsure why. R52 stated she has not had any diarrhea. R52 stated that she was in her room with the door closed, and was isolated, and not sure why.

On 12/21/2023 at 12:30 PM, V15, Medical Director, stated he was the Medical Director for the facility. V15 stated he was notified of residents having GI symptoms. V15 stated he would have not been notified of every resident

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that had the symptoms, because he is not everyone's physician. V15 stated he was not aware of specific number of residents and staff with the GI symptoms. V15 stated if there was an outbreak, he would be notified. V15 stated he is not sure what that number is, and the facility would have the specifics. V15 stated he would expect the facility to contact the health department and follow their recommendations. V15 stated he would expect the facility to communicate the recommendations to him. When asked why the residents were only tested for COVID? V15 stated during this time, COVID had more GI symptoms than respiratory. V15 stated there are more than COVID respiratory infections, there is RSV and Flu as well. V15 stated it takes time for norovirus results to come back. V15 stated, "The first step with residents with GI symptoms would be isolation. The resident should be in isolation. It would start there." V15 stated he had 1 resident with IV therapy recently but is unsure, due to not having the chart, if this was because of the nausea or vomiting or poor intake.

The facility's policy Infection control, dated 12/17/2019, did not address what type of infection control procedures should be implemented regarding Gastroenteritis.

Centers for Disease Control and Prevention (CDC) "2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, last updated July 2023 documents "Documented LTCF (long-term care facilities) outbreaks have been caused by various viruses (e.g., influenzas virus, rhinovirus, adenovirus, norovirus and bacteria (e.g., group A streptococcus, B. Pertussis, non-susceptible S. pneumoniae, other MDROs (multi drug resistant

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S9999	Continued From page 41 organisms, and Clostridium difficile). Thes pathogens can lead to substantial morbidity and mortality and increased medical cost; prompt detection and implementation of effective control measures are required." The Guidelines documented "Contact Precautions also apply where the presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission." The Guidelines documented "healthcare personnel caring for patients on Contact precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE (personal protective equipment) upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g., VRE, C. difficile, noroviruses and other intestinal tract pathogens; RSV)." (A)	S9999		