Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005011	A. BUILDING: ______ B. WING ______	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEWANEE CARE HOME	**144 JUNIOR AVENUE KEWANEE, IL 61443**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigations: 2421143/IL169685 2421205/IL169751 2421365/IL169952 2421388/IL169983	S 000		
S9999	Final Observations Statement of Licensure Violations I of III: 300.610a) 300.1210b) 300.1210d)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999		

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S9999	Continued From page 1 care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to adequately manage a resident's Coumadin (anticoagulant medication) dosage to ensure the medication was reaching therapeutic levels, develop a policy on anticoagulant medication management, and obtain treatment adjustment from the physician for a non-therapeutic INR (International Standardized Ratio for clotting in the blood) lab result for a resident with a history of a high risk blood clotting disorder for one of three residents (R3) reviewed for High Risk Medications. This failure resulted in R3 requiring emergency medical services followed by a medical transfer and admission to a tertiary critical care (higher level/specialized) hospital for treatment of Acute Ischemic Stroke Left MCA (Middle Cerebral Artery) territory with right facial droop and weakness, Lactic Acidosis (lactic acid in the bloodstream) and Subtherapeutic INR, resulting in R3 experiencing aphasia, dysphagia, right sided weakness, mental anguish, and hospitalization for 17 days.	S9999		

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Findings include:

R3's Physician Order Sheet, dated 11/1/23-2/29/24, documents R3 has diagnoses including but not limited to Hypertension, History of Pulmonary Embolism, History of other Venous Thrombosis and Embolism, Antiphospholipid Syndrome and Heart Failure. This order sheet documents R3 has a laboratory order for "PT (Prothrombin)/INR one time only related to Personal History of Pulmonary Embolism, Personal History of other Venous Thrombosis and Embolism, until 1/25/24." This order has a start date of 1/25/24. This order sheet also documents a medication order for Warfarin Sodium (Coumadin) two and a half milligrams to give 1 tablet by mouth one time a day every Monday, Wednesday, and Friday for blood thinner, start date 1/12/24. This order sheet also documents a medication order for Warfarin Sodium five milligrams to give 1 tablet by mouth one time a day every Tuesday, Thursday, Saturday, and Sunday for blood thinner, start date 1/11/24. No other Warfarin orders were started after 1/12/24 for R3.

R3's Laboratory report, dated 1/26/24, documents R3's INR result was 1.3. This report also documents an INR range for Standard Anticoagulant is 2.0-3.0 and Aggressive Anticoagulant is 2.5-3.5.

On 2/21/24 at 12:10 PM, V13 (R3's Family Member) stated "I am going off what the neurologist doctor said to me. When we were in the emergency room, I don't know his name but after she was taken there, I asked specifically what caused her stroke and he said likely medication management. Her level was too low

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for the Coumadin to be considered therapeutic. (R3) is still having left side weakness, aphasia (difficulty formulating thoughts into words and speaking) and dysphagia (difficulty swallowing). She has to eat soft foods only which she cries about. She was able to eat regular food before this. (R3) also has suffered memory loss with her stroke."

On 2/21/24 at 1:40 PM, V1 (Administrator in Training) stated "I don't know if (V8 R3's Primary Physician) was notified of the 1/26/24 laboratory result for (R3's) PT/INR. If he was notified it should be in the progress note or a new updated order would be in place."

On 2/21/24 at 2:00 PM V9 (V8's Medical Office Licensed Practical Nurse) stated "I do not see where we (doctor office) were ever notified of the PT/INR results for (R3) on or after 1/26/24."

R3's Physician visit history, provided by V1 on 2/21/24, documents that the last visit from V8 was on 12/12/23.

R3's Nursing Progress notes, dated 1/11/24-2/9/24 do not document that V8 was ever notified of R3's PT and INR results that were completed on 1/26/24.

R3's Nursing Progress note, dated 2/10/24 at 8:15 AM, documents R3 was transferred to a local hospital after appearing to have experienced a change in "Cognitive Ability."

R3's Nursing Progress note, dated 2/10/24 at 1:27 PM, documents "Informed by Emergency Room nurse That (R3) had Stroke with Left sided weakness and sepsis. Resident will be re-transferred to (tertiary critical care hospital)."

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R3's Emergency Room provider notes, dated 2/10/24 at 9:22 AM, documents "This 66-year-old woman sent from (the facility) because mental status change concerning for possible stroke. The (facility) said that the right sided face is drooping compared to normal, and (R3) is not speaking as she normally does."

R3's Emergency Room hospital record, dated 2/10/24 at 12:15 PM, documents R3 is being transferred to a tertiary hospital for "Acute ischemic stroke left MCA (Middle Cerebral Artery) territory with right facial droop and weakness, Lactic acidosis rule out sepsis and Subtherapeutic INR." This record also documents "Brief Summary: Work up in Emergency Room shows INR subtherapeutic at 1.3. Patient had a CTA (Computed Tomography Angiography) of the head which showed acute ischemic infarct in the left MCA territory in the left temporal lobe region, no hemorrhage."

On 2/26/24 at 11:20 AM V19 (Pharmacist) stated, "(R3's) INR of 1.3 is not within therapeutic range. A physician should have been notified to possibly adjust (R3's) Warfarin dose."

On 2/26/24 at 12:45 PM V15 (R3's Primary Hospital Physician) stated, "(R3) is currently in the hospital being treated for the effects of her stroke. (R3's) sub-therapeutic INR levels contributed to (R3's) stroke. (R3) had a history of developing blood clots."

On 2/26/24 at 12:55 PM V16 (R3's Neurologist) stated, "(R3) had a history of a disorder called Anti-Phospholipid Syndrome which is a disorder that puts (R3) at a high risk for developing blood clots. (R3) also has a history of a Pulmonary

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S9999	Continued From page 5 Embolism and Venous Thrombosis. (R3's) INR levels should have been watched closely and as soon as the facility knew (R3's) INR levels were 1.3 (sub-therapeutic) on 1/26/24 the facility should have notified the physician to get (R3's) Warfarin (anti-coagulant) dose adjusted to ensure (R3's) INR levels were therapeutic to prevent blood clots. Sub-therapeutic INR levels would have caused a clot to throw and caused (R3's) stroke." On 2/27/24 at 10:15 AM, V1 (Administrator in Training) stated "We do not have a Coumadin specific policy or one for anticoagulant monitoring. We use the Protime (PT) Flowsheet for residents on Coumadin and that is where nurses will document INR results and then dose changes and when the Physician was notified of them." V1 confirmed R3's Protime flowsheet has not been documented on since December of 2023. The facility's Notification of Change in Resident Condition or Status policy, dated 10/12/05, documents "The facility and/or facility staff shall promptly notify appropriate individuals (i.e., Administrator, Director of Nursing, Physician, Guardian, Health Care Power of Attorney, etcetera) of changes in the resident's medical/mental condition and or status. The nurse supervisor/charge nurse will notify the resident's attending physician or on call physician when there has been; A need to alter the resident's medical treatment significantly, Abnormal lab findings." The facility's Laboratory Tests policy, dated 9/27/17, documents "Appropriate laboratory monitoring of disease processes and medication requires consideration of many factors including	S9999		

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concomitant disease(s) and medication(s), wishes of the resident and family and current standards of practice."

"A"

Statement of Licensure Violations II of III:
300.610a)
300.1210b)
300.1210d)6)
300.2210b)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.

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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 300.2210 Maintenance

b) Each facility shall:

5) Maintain all furniture and furnishings in a clean, attractive, and safely repaired condition.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to assess resident surroundings for a safe environment and failed to develop and implement interventions to promote a safe environment for one of three residents (R2) reviewed for accidents in a sample of 12. These failures resulted in R2 sustaining a right shin wound from hitting her right shin on an exposed sharp bolt located on R2's bedframe on two separate occasions 27 days apart. The first occurrence resulted in R2's right shin wound becoming infected, and the second occurrence resulted in R2 requiring an Emergency Room visit to obtain three staples to close a right shin laceration.

Findings include:

The facility's Quality Care Reporting policy dated 12-12-23 documents, "Policy: (The Facility) works

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to continuously improve residents care, safety and operations within the facility. A Quality Care Reporting Form will be completed to assist in the Quality Assurance process. Purposes: To help identify problems or potential problems. To act as a record, when analyzed, will prevent similar mishaps or injuries. To improve quality of resident care and overall safety in the facility. Procedure: Charge Nurse will: 1. Complete a Quality Care Reporting Form for happenings out of the ordinary which results in a potential for injury, or actual injury or damage to: resident, visitor, employee or property. Administrator and/or DON (Director of Nursing) will: 1. Review the Quality Care Reporting form for completeness. 2. Investigate all reports upon receipt. 3. Obtain additional information from resident, staff, family, etc. (et cetera) as needed. The following list contains examples of action to be taken: h. Repair or replace equipment.

R2's BIMS (Brief Interview Mental Status) dated 12-05-2023 documents R2 is Cognitively Intact.

R2's A.I.M (Acute Illness Management) For Wellness Change in Status Record dated 6-22-23 documents R2 had a change in skin integrity/wound appearance. Right lower leg 7.5 cm (centimeter) by 3.5cm unstageable wound. This same form documents R2's comments/response to event was, "I ran into my bed with the w/c (wheelchair) a week ago. I thought you knew. The third shift nurse knew."

R2's A.I.M (Acute Illness Management) For Wellness Change in Status Record dated 6-22-23 documents R2 had a change in skin integrity/wound appearance. New or worsening pus at wound, skin, or soft tissue noted. R2 may need a prescription for an antibiotic. Event first

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noted on 6-12-23. Right lower leg 7.5 cm (centimeter) by 3.5cm unstageable wound. This same form documents R2's comments/response to event was, "I ran into my bed with the w/c (wheelchair) a week ago. I thought you knew. The third shift nurse knew."

R2's Electronic Medical Record did not include any documentation on R2's right shin area from 6-12-23 to 6-22-23.

R2's MAR (Medication Administration Record) documents an order dated 6-23-23 for Keflex (antibiotic) 500mg three times a day until 7-7-23 for right leg.

R2's Progress Note dated 6-24-23 and signed by V17 (Licensed Practical Nurse/LPN) documents "Keflex continues for area on right leg with NAR (No Adverse Reactions) noted. Area remains red and swollen."

R2's Progress Note dated 6-24-23 documents "Antibiotic continues for cellulitis (infection) to right leg. Area remains red and warm to touch."

R2's Physical Therapy and Rehab Specialist Initial Evaluation dated 6-27-23 documents, "R2 states she recently ran her wheelchair into the bed and her big toe into the doorframe which has left a hematoma on her right shin and cut on her right big toe."

R2's Care Plan 6-22-23 (date of injury) through 7-19-23 does not include an intervention to protect R2 from sustaining further injury from R2's exposed bed frame bolts.

R2's Progress Note dated 7-19-23 and signed by V17 (LPN) documents, "(R2) was going into her

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room and hit the edge of her bed causing a 1.5 cm (centimeter) laceration to her RLE (Right Lower Extremity). Resident sent out to local ED (Emergency Department)."

R2's Local ED Noted dated 7-19-23 documents "(R2) to the ED today via EMS (Emergency Medical System) from (the facility) with c/o (complaints of) laceration to right lower leg on shin. Three staples applied by V18 (Local ED Physician)."

R2's Progress Note dated 7-19-23 and signed by V17 documents, "(R2) returned to facility per facility van. Three sutures noted to RLE. Keep wound clean and dry. Put a thin layer of antibiotic ointment. Put ice pack on site if swelling occurs for 20 minutes. (R2) denies any pain or discomfort at this time."

On 2-21-24 at 12:27 PM R2 was sitting in her room in her manual wheelchair beside her bed. R2's bed frame had a pool noodles (foam noodles) taped to her bedframe. Foam noodles were loose and sagging leaving R2's bed frame bolts exposed.

On 2-26-24 at 10:00 AM R2 was sitting in her room in her manual wheelchair. R2 sitting in between her bed and an empty bed. The empty bed was noted to have two sharp bolts sticking out approximately two inches from the bed frame in close proximity to R2's right leg.

On 2-26-24 at 10:05 AM R2 stated, "The facility tries to blame everything on my electric wheelchair. I had two injuries because of the bolts located on my bed frame. I told (V1) (AIT/Administrator in Training) the first time about the bolts and they did nothing to fix the issue, just

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that I need to learn how to drive my electric wheelchair better. The second injury I had to my right shin was because of the same bolts sticking out. (The facility) had maintenance come to my room and pad my bed frame to cover the bolts, but they still won't pad this other bed frame. My room is tiny and it's hard to maneuver between two beds with my wheelchair and bolts sticking out of the frame." R2's right shin had two quarter size deep indentations where her previous injuries had occurred from the R2's bed frame.

On 2-26-24 at 12:00 PM V14 (Former Maintenance Director) stated, "A few months ago (V1) came and got me and asked me if we had pool noodles to cover up the bolts that were sticking out on (R2's) bed frame. (V1) said (R2) had hit her leg on the bolts before and had just hit her leg aga on the bolts that were sticking out of (R2's) bedframe. (R2) busted her leg open and had to get stitches the second time. The beds at the facility are so old and there are four bolts that stick out approximately two inches from the bed frames. Those bolts were used to attach full side rails back in the day. Full side rails are not used anymore so the bolts just stick out. The facility did not provide me with any tools to cut the bolts off to make the bolts smooth. There are still beds there with exposed bolts."

On 2-27-24 at 11:08 AM V17 stated, "On 7-19-23 (R2) reported to me that she had hit her right shin on her bedframe. I was in the room but didn't inspect (R2's) bed frame fully. (R2) is alert and is able to tell you exactly what she hit her right shin on."

On 2-27-24 at 11:15 AM V1 (AIT) stated there were no interventions developed or implemented to address R2's bed frame after R2 hit her shin

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on her bed and becoming infected on 6-22-23. R2 hit her shin again on the bed frame on 7-19-23 sustaining a laceration that required sutures.

"B"

Statement of Licensure Violations III of III:
300.610a)
300.1210b)3)4)5)

Section 300.610 Resident Care Policies
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3) All nursing personnel shall assist and

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encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide an adequate amount of sit-to-stand mechanical lifts to transfer and toilet residents timely for nine of nine residents (R3-R11) reviewed for accommodation of needs in the sample of 12. These failures resulted in R3 soiling her brief and sitting in urine and feces for over an hour at a time on multiple

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occasions, causing R3 visible emotional distress, embarrassment, and anxiety, and resulted in R4 experiencing unwanted urinary incontinence and embarrassment.

Findings include:

The facility's Limited Resident Lift Program (undated) documents "1. Equipment: Must have enough lift, slings, etc. to effectively transfer all heavy residents in a timely manner. Goals: 4. Maximize safe, functional independence without compromising the resident's dignity and rights. Compliance: D. Mechanical lifting devices and other equipment /aids: b. Mechanical lifting devices and other equipment/aids will be maintained regularly and kept in proper working order."

The Facility Assessment Tool dated 2-21-24 documents, "Part 2: Services and Care We Offer Based on our Residents' Needs. Resident support/care needs- Bowel/bladder: Bowel/bladder toileting programs, incontinence prevention and care, intermittent or indwelling or other urinary catheter, ostomy, responding to requests for assistance to the bathroom/toilet promptly in order to maintain continence and promote resident dignity."

On 2-21-24 at 11:00 AM V1 (Administrator-In-Training) provided a list of current residents (R4-R11) requiring the use of a sit-to-stand mechanical lift machine for transfers and toileting.

On 2-27-24 from 10:00 AM through 10:15 AM a tour of the building was done. During this tour the facility had one sit-to-stand mechanical lift

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machine within the building, to use for four hallways that occupied residents.

1. R3's BIMS (Brief Interview of Mental Status) dated 12-13-23 documents R3 is cognitively intact.

R3's Care Plan dated 2-8-24 documents R3 requires staff assistance for transfers and toileting.

R3's Progress Notes document R3 was hospitalized on 2-10-24 and still remains hospitalized.

R3's Grievance/Complaint Report Form dated 2-8-24 and signed by V1 (Administrator-In-Training) documents, "(R3) complaints of not being able to go to the bathroom as quick as she need to due to second stand-up lift broke down. (R3) states she has urgency when she needs to go. Method of correction or disposition of complaint: Staff in-serviced to take resident to the bathroom first or as quick as they can does have past history of chronic urinary symptoms and urgency. (R3) also educated that we could use bed pain if she desires as another means to toilet."

On 2-21-23 at 12:10 PM, V13 (R3's Family Member) stated "(R3) reported to me that they (the facility) only have one sit to stand so they have to wait a long time to go to the bathroom. She is not getting the help she needs. (R3) will not be going back there (the facility) because she is embarrassed. (R3) was visibly crying to me and my mother that the facility did not have a machine to get her up and toilet her. (R3) told us she had to sit in poop and pee for hours a lot of different days. (R3) voiced the concerns to (V1

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Administrator-In-Training) and (V1) told (R3) she would have to use the bed pan. (R3) does not like having to use a bed pan and should not have to."

2. R4's current Care Plan dated 2-21-24 documents R4 requires full assistance of staff and a sit-to-stand as needed for transfers and toileting.

On 2-27-24 at 10:40 AM R4 was sitting in her recliner. R4 stated she sometimes wets her pants waiting on someone to transfer her. R4 stated she tries to "hold it" but it just comes out after waiting so long for the machine (sit-to-stand). I do not like sitting in wet pants. It is embarrassing."

3. R5's current Care Plan dated 2-21-24 documents R5 requires full assistance of staff and a sit-to-stand for transfers and toileting.

On 2/28/24 at 1:15 PM R5 was lying in bed in her room. R5 confirmed she needs assistance to get out of bed with a lift device. R5 stated "I have to wait a long time. Sometimes an hour and it's usually when I hit my call light because they only have so many machines and other people use them too. It is a long time to wait when I have to go to the bathroom."

4. R6's current Care Plan dated 2-21-24 documents R6 requires full assistance of staff and a sit-to-stand for transfers and toileting.

5. R7's current Care Plan dated 2-21-24 documents R7 requires full assistance of staff and a sit-to-stand for transfers and toileting.

6. R8's current Care Plan dated 2-21-24

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documents R8 requires full assistance of staff and a sit-to-stand lift as needed for transfers and toileting.

7. R9's current Care Plan dated 2-21-24 documents R9 requires full assistance of staff with a sit-to-stand lift for transfers and toileting.

8. R10's BIMS Evaluation dated 11-27-24 documents R10 is cognitively intact.

R10's current Care Plan dated 2-21-24 documents R10 is unable to transfer independently due to the diagnoses of weakness and uses a sit-to-stand lift with staff assistance.

On 2-28-24 at 1:25 PM R10 was sitting in his wheelchair in his room. R10 stated, "There is only one lift (sit-to-stand) here and it is usually on the other side of the building. I try to put my call light on earlier than I think I will need it, so I don't pee myself. Sometimes it takes half an hour to over an hour for the staff to get me to the toilet once I use my call light. I wear an (adult brief) so I wet myself in it when I need to. I don't like wetting myself. What am I supposed to do?"

9. R11's current Care Plan dated 2-21-24 documents R11 requires full assistance of staff and a sit-to-stand as needed for transfers and toileting.

On 2-26-24 at 12:35 PM R11 stated, "I just get myself up to the bathroom if staff do not help me in time. I do not wait for the lift."

On 2-27-24 at 10:20 AM V20 (CNA/Certified Nursing Assistant) stated, "There is not enough sit-to-stand lift to toilet the residents timely. We only have one lift for all four hallways. (R11) gets

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upset, yells, and screams and sometimes soils herself. Residents are also late getting up for meals at times."

On 2-27-24 at 10:50 AM V21 (CNA) stated, "The residents have to wait a long time sometimes to get up to the toilet because we only have one sit-to-stand lift. Residents will soil themselves at times before we can get to them."

On 2-27-24 at 1:00 PM V1 (Administrator-In-Training) stated, "The second sit-to-stand lift has been broken for about a month now and we are awaiting parts. There is one machine in the building."

On 2-27-24 at 2:13 PM V25 (CNA) stated, "Residents were having to wait longer periods of time due to only having one sit to stand lift. R3 would always get upset having to wait longer periods of time because she would have to use the restroom. R5 also got upset multiple times when it was time for her to lay down and she had to wait because we only had the one sit to stand."

On 2-27-24 at 2:19 PM V24 (CNA) stated, "I work second shift mostly. It is very difficult to get people up timely when we only have one sit-to-stand in the building. (R3) has requested to go to the bathroom before and had to wait for an hour and a half, because the sit-to-stand was being used on other residents. (R3) was very upset and very anxious about this and I don't blame her. Sometimes residents because they need a sit-to-stand lift must wait until its done being used on other residents. (R11) is a high fall risk and will get up on her own if we cannot get to her call light timely. There have been multiple times (R11) has transferred herself to the toilet and should not have had to."

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