STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005391	A. BUILDING: _____ B. WING _____	C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON REHAB & HCC	1409 NORTH MAIN STREET BENTON, IL 62812

(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 Investigation of Facility Reported Incident of January 3, 2024/IL170094	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)4)5) 300.1210c) 300.1210d)3)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which	S9999		

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S9999	Continued From page 1 allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.	S9999		

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BENTON REHAB & HCC	1409 NORTH MAIN STREET BENTON, IL 62812

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S9999	Continued From page 2 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to implement interventions and follow facility policies to prevent falls for three of three residents (R1, R2, and R3) reviewed for falls in the sample of 3. These failures resulted in R1 having injuries including a dislocated shoulder and an intertrochanteric fracture of the right femur. The findings Include: 1. R1's Face Sheet documents an admission date of 8/16/23 with diagnoses including: Hemiplegia following unspecified cerebrovascular disease affecting right dominated, Essential hypertension,	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON REHAB & HCC	1409 NORTH MAIN STREET BENTON, IL 62812

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S9999	Continued From page 3 End stage renal disease, Type 2 diabetes with diabetic peripheral angiopathy, Unspecified sequelae of cerebral infarction, Unspecified systolic heart failure, Peripheral vascular disease, unsteadiness on feet, Cerebral infarction, reduced mobility, Muscle wasting and atrophy, Aphasia, and right peri trochanteric femur fracture with a long cephalomedullary nail (Closed 2 part intertrochanteric fracture of right femur). R1's Minimum Data Set (MDS) dated 08/23/23 documents a Brief Interview of Mental Status (BIMS) of 14, indicating R1 is cognitively intact. Section G documents: self-performance for transfers as an extensive assistance (resident involved in activity, staff provide weight bearing support) and support as "3" indicating two persons physical assistance, toilet use is documented as a "3" for self-performance indicating; extensive assistance (resident involved in activity, staff provide weight bearing support) and support as a "2" (one-person physical assist). R1's nursing summary dated 08/21/23 notes, right side flaccid. R1's Nursing summary dated 11/21/23 notes, alert and oriented with forgetfulness. R1's Fall Risk Assessment dated 08/16/23 documents a score of 18, this form documents a score of 10 or higher is a high risk. R1's Care Plan documents: Category: Falls: Resident has risk factors that require monitoring and intervention to reduce potential for self-injury. Has CVA (Cerebrovascular Accident) impacting mobility, hemodialysis three times weekly effecting endurance with a start date of 08/23/23. The Goal dated 02/21/24 documents: Resident will follow safety suggestions and limitations with supervision and verbal reminders for better control of risk factors through next 90 days.	S9999		

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S9999	Continued From page 4 Interventions are documented as: Review quarterly and as needed during daily care and services of resident's plan for safety, giving verbal cues as needed to gain resident participation in minimizing risk factors and injury with a start date of 08/23/23. Encourage and assist placement of proper nonskid footwear with a start date of 08/23/23. Attempt to anticipate needs: toileting, hydration, hunger and provide cares before resident attempts to fulfill on own with a start date of 08/23/23. Fall risk assessment quarterly and as needed with change in condition or fall status with a start date of 08/23/23. Resident reminded to use call light when assistance needed for transfers and help with toileting. Call do not fall sign put in room with a date of 10/17/23. Non-skid strips applied to bedside for fall prevention with a date of 10/26/23. Reeducate on safety repeat demonstration on call light use with a date of 11/05/23. Grabber provided so resident can reach things while in bed with a date of 11/15/23. Resident to wear proper fitting shoes with a date of 12/13/23. Locked wheels on bed and wheelchair with a date of 12/16/23. ER regarding the fall, see order with a date of 01/03/24. R1's Nurse's Note dates 11/04/23 at 11:55 PM documents: R1 fell on floor laying on right side, R1 stated "I have to take a s***" assisted up R1 and taken to the toilet. R1 had already became incontinent of bowels. ROM same denies hitting head. No apparent injury noted. Resident reminded to use call light for assistance, R1 voices understanding. R1's Nurse's Notes on 11 /06/23 at 8:30 AM document: R1 complains of shoulder pain form	S9999		

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BENTON REHAB & HCC	1409 NORTH MAIN STREET BENTON, IL 62812

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S9999	Continued From page 5 his fall on 11/04/23 left a message with V11's (Medical Doctor) office for x-ray waiting for call back. At 8:45 AM x-ray ordered. On 11/08/23 X-ray order shows dislocation to shoulder and sling ordered. R1's patient report form radiology dated 11/08/23 documents; reason for visit: post fall with complaints of pain to the right upper arm and shoulder with a date of service of 11/07/23. The section titled, Impressions: Inferior shoulder dislocation. There was no new fall investigation for R1 provided for review for the fall occurring on 11/4/23. (Resident reminded to use call light when assistance needed for transfers and help with toileting was implemented 10/17/23) R1's Nurse's Note on 01/03/24 at 5:45 AM documents: At approximately 3:00 AM CNA (Certified Nursing Assistant) notified V4 (Licensed Practical Nurse/LPN) of R1 on floor in the bathroom. CNA told V4 she assisted R1 onto toilet and gave R1 the call light to ring when he was done. CNA notified V4 (LPN) right after that R1 was lying on his back on the floor. R1 denied hitting his head at the time. R1 has complaints of pain to right hip. R1 was assisted back to bed. V11 (Medical Doctor) sent R1 to Emergency Room (ER) for evaluation for fracture. When EMS (Emergency Medical Service) arrived R1 was loaded on the stretcher, R1 told EMS he hit his eye when he fell. R1 was transported to hospital via ambulance at approximately 3:30 AM.	S9999		

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S9999	Continued From page 6	S9999		

R1's Quality Care Reporting Form documents an alleged fall on 01/03/24 at 3:00 AM, ROM (Range of Motion/Extremities): Unable to move right hip, Pain Location: right hip, What does the resident say happened: fell getting off toilet, what fall prevention techniques were in use prior to fall: call light within reach, slipper socks on, Why did the fall occur: res non-compliant with call light use, What are you doing differently to prevent another fall right now: Encourage resident to use call light. The facility document titled, " Investigation Report for falls" dated 01/03/24 documents: "Areas of concern identified for further analysis: with "Res (Resident) non-compliant with call light use" and "what new intervention was implemented to prevent any further falls?" with "Remind/encourage res (resident) to use call light for assistance" as a response. The section titled, Falls: Resident-Root Cause with R1 at 3:00 AM fracture hip, fell off toilet, educate on call light.

R1's Nurse's notes on 01/10/24 at 7:30 PM document: R1 returned to facility via a stretcher with EMS from the hospital. R1's returning diagnosis was right femur fracture with IM (Intramedullary) nail repair.

R1's report from (Orthopedic specialist) dated 01/31/24 documents: referral to Physical Therapy with a diagnosis of Closed 2-part intertrochanteric fracture of right femur, initial encounter.

On 02/21/24 at 10:55 AM, R1 stated he had a fall in the bathroom during the night. R1 stated, he was assisted to the toilet, but he was finished, and he was trying to transfer himself back to the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON REHAB & HCC	1409 NORTH MAIN STREET BENTON, IL 62812

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S9999	Continued From page 7	S9999		

wheelchair as he was ready to go back to bed. R1 said, he always required assistance for a safe transfer. R1 stated, he was ready to go to bed and he thought that they didn't want to have to put him to bed. R1 stated, he doesn't recall how long he laid on the floor of the bathroom or how long he had waited on the toilet to be transferred to his wheelchair.

On 02/21/24 at 1:15 PM, R1 stated he has had some falls. R1 stated he will have dreams at night that he can still walk, and he will need something or get confused and will get up. That is how he fell the last time. He cannot put any weight on his leg or knee, it just gives out.

On 02/23/24 at 2:52 PM, V4 (Licensed Practical Nurse) stated, she worked the evening of 01/03/24 when R1 had the fall that fractured his femur. V13 (CNA) went down to assist R1 to the toilet. V13 stated R1 asked her to leave the bathroom while he was using the toilet. V4 stated she is unaware if V13 stayed outside the door and waited or if she left, she does not know V13 told her she gave R1 the call light before she left him. V4 stated R1 is non-compliant with using a call light and he does get confused, has impaired decision making, and has had hallucinations before at night. V4 stated, V13 was new and was not that familiar with R1.

Attempts to contact V13 for an interview during the survey were unsuccessful.

On 02/22/24 at 2:45 PM, V2 (Director of Nurses/DON) stated residents including R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005391	A. BUILDING: _____ B. WING _____	C 02/23/2024

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BENTON REHAB & HCC	1409 NORTH MAIN STREET BENTON, IL 62812

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S9999	Continued From page 8	S9999		

should not have the same intervention used more than once. V2 stated she does see where; reeducation on using his call light was used more than once as an intervention for R1's falls. V2 also stated, "send to ER (Emergency Room) for evaluation" is not an appropriate intervention, it does not help prevent any future falls. V2 stated, she does see where R1 has had several falls.

On 02/21/24 at 10:35 AM, V9 (CNA) stated there should be a list at the nurse's station that has all of the interventions listed. She stated that the nurses usually tell the CNA's the new interventions. V9 states that we don't always know what is going on. V9 stated she did not know what intervention was put into place after R1's fall.

On 02/21/24 at 10:35 AM, V10 (CNA) stated, the nurses are supposed to tell us about new interventions that are put into place. V10 stated that she doesn't know anything about an intervention list. V10 (CNA) also states that she doesn't know the interventions for R1 after his fall.

On 02/21/24 at 10:40 AM, V6 (LPN) stated that there is no list of fall interventions kept at the nurse's station. V6 said she is knowledgeable of interventions by looking at the care plans or from report from the nurse that she is relieving. V6 said that the nurses inform the CNA's whenever there is a new intervention put in place.

On 02/21/24 at 10:00 AM, V1 (Administrator) stated they have had people with several falls, they are just not on the fall log, they have been

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	IL6005391	A. BUILDING: _____ B. WING _____	C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON REHAB & HCC	1409 NORTH MAIN STREET BENTON, IL 62812

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S9999	Continued From page 9	S9999		

behind with the fall log, but all the investigations should be in the fall book. V1 stated, they do not do fall investigations with interviews and that type of investigation if the fall is unobserved, because it is unobserved.

On 02/21/24 at 10:00 AM the fall book was reviewed, there was one fall investigation in the book, there were no fall investigations for R1.

On 02/22/24 at 10:30 AM, V2 (Director of Nursing) stated she has not been at the facility that long but there should definitely be more than four falls on the fall log for January and she does not know why there are no falls on the fall log for February. V2 also stated there should be more than one fall investigation in the fall book, she does not know why there is only one investigation in the book.

On 02/21/24 at 2:40 PM, V3 (MDS/ Care Plan Coordinator) stated that a Fall Risk Assessment should be done with every fall. V3 stated that the floor nurse that is taking care of the resident at the time of fall is responsible for doing the Risk Assessment. V3 also stated that the nurse in charge of the resident at the time of fall is responsible for implementing an appropriate intervention and writing that on the care plan that is in the chart. V3 stated the falls are reviewed every morning in the Quality meetings with department heads. V3 stated they may change an intervention at that time. V3 was asked if the charts go to the meeting, so they can review the care plan to see what intervention if any was put into place by surveyor. V3 replied "no but we should ". V3 was asked if the Risk assessment

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BENTON REHAB & HCC	1409 NORTH MAIN STREET BENTON, IL 62812

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S9999	Continued From page 10 was reviewed during the QA meeting and she said "no, but it should be." V3 stated, the charge nurse also fills out the fall packet when a fall occurs. V3 was asked if the Fall Risk Assessment tool was in the fall packet so it is available for the nurse, and she said "no." 2. R2's "Profile Face Sheet" documents an admission date of 2/22/2022. R2's Physician Order Sheet documents diagnoses of Pneumonia, CHF (Congestive Heart Failure), Respiratory Failure with hypoxia, Increased INR (International Normalized ratio). Additional diagnoses were noted on hospital notes dated 2/16/2024 of diagnosis of Bell's palsy, COPD (Chronic Obstructive Pulmonary Disease), HTN(Hypertension), GERD (Gastroesophageal Reflux Disease), Hypothyroidism, Pneumonia, Dementia and COVID-19. R2's Fall Risk Assessments includes assessments dated 9/12/2023 and 12/12/2023 and document the following. The score on 9/12/2023 is documented as 17. The score on 12/12/2023 is documented as 18. This assessment tool reads: 10 points or more = High Risk Score. There are no other assessments noted on this document. Request of more recent Fall Risk Assessments were not received. R2's Care Plan for the section of "falls" contains documentation of review date of 6/11/2023. R2's Care Plan documents a "Problem/ Need" of "resident has risk factors that require monitoring and interventions to reduce the potential for self-injury." An "Approach/ Intervention" dated 2/22/22 documents "Review quarterly and PRN (as needed) resident's ADL (Activities of Daily	S9999		

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BENTON REHAB & HCC	1409 NORTH MAIN STREET BENTON, IL 62812

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S9999	Continued From page 11	S9999		

Living), mobility, cognitive, behavior, and overall medical status. IDT (Interdisciplinary Team) review of changes and needs w/ (with) resident and/or responsible party (when choose to attend) during care plan. Discuss fall related information to review and revise plan as needed." The following interventions are handwritten on the care plan: Reminded (R2) to use call light, continue with skilled therapy dated 2/8/22; non-skid socks and education on call light re-introduced, dated 2/8 (no year documented); reminded R2 when feeling sleepy go lay in bed, dated 7/15/22; 15 minute checks, dated 8/9/22; remind R2 to wear O2 (oxygen) as MD ordered, offer to plug in cell phone at bedtime, dated 8/13/22; send R2 to ER, remind R2 to ask for assistance when transferring, dated 10/6/22; remind staff to offer R2 assist, continue above intervention, dated 10/21/22; Show R2 where urinal is placed, remind R2 if he can't find items to ask for help, dated 10/31/22; frequent visual checks, educate R2 to sit more towards middle of bed, dated 11/29/22; ensure R2 has O2 on and is properly working, refer to skilled therapy, dated 12/19/22; ensure O2 tubing doesn't interfere with ADL's, dated 2/2/23; red tape on O2 tubing so R2 can see where tubing is placed, dated 2/9/23; non-skid strips in front of recliner on floor, dated 3/13/23; remove recliner from room, dated 5/9/23; call don't fall sign in room as a reminder, dated 8/9/23; ER after fall with right hip pain, no new orders, dated 8/9/23; orthostatic BP (blood pressure) x 3 days report if not WNL (within normal limits) to MD, dated 8/15/23; re-educate on use of call light when tried to prevent falling out of wheelchair, dated 8/28/23; PT/ ST (Physical Therapy/ Speech Therapy) orders see POS (Physician's Order Sheet), dated 9/23/23; D/C (discontinue) therapy, dated 10/16/23. There was no new intervention noted for the falls on

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BENTON REHAB & HCC	1409 NORTH MAIN STREET BENTON, IL 62812

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S9999	Continued From page 12 2/16/2024 nor 2/18/2024. R2's "nurses notes" for the date of 2/16/2024 at 5:20 AM reads: Heard res (R2) calling out for help found R2 laying on right side near wheelchair. R2 is able to move all ext (extremities) except limited ROM (Range of Motion) to right wrist, lg (large) hematoma to right wrist. Documentation on 2/16/2024 at 5:59 AM reads: R2 states "I fell asleep" in wheelchair. V8 (CNA) had made several attempts to get R2 to lay down and refused each time. Late entry 5:25 AM Phoned ambulance service. 6:00am R2 to ER for evaluation. On 2/16/2024 at 9:25 am returned from (name of local hospital) Right wrist sprain. Ace wrap applied to area. No new orders. Investigation Report for Falls for R2 completed for the fall on 2/16/2024 documents the following: the areas titled, "areas of concern identified for further analysis" this area is blank. Another area titled, " what new interventions was implemented to prevent any further falls?" was blank as well. R2's "Nurses Notes" by V10 (LPN) for 2/18/2024 document, "CNA at NS (Nurse's Station) heard noise in (R2's Room). Found (R2) laying on floor called for the nurse, body assessment shows no apparent injury. (R2) denies pain, moves all extremities (ext.) without difficulty. Assisted up x2 and gait belt into wheelchair then into bed after couple mins. ROM (Range of Motion) WNL (Within Normal Limits) denies hitting head. Denies pain or discomfort 'not even this hurts.' (R2) holding right wrist, 'it's almost healed already.' (R2) call light was in reach prior to fall, had grippie socks on, 1:1 to place call for assist	S9999		

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S9999	Continued From page 13	S9999		

at least for a few days. (R2) voiced understanding states, 'I will, I will.' When asked what he was trying to do 'I stood up tried to get into my wheelchair but hit the edge and I just fell down.' (R2) was going to put pictures away."

Investigation Report for Falls for R2 completed 2/19/2024 for the fall occurring on 2/18/24 documents the following: the areas titled, " areas of concern identified for further analysis" is blank. Another area titled "what new interventions was implemented to prevent any further falls?" was blank as well.

A document titled "Quality Care Reporting Form "date 2/18/2024 for the fall occurring that date was reviewed. This document has information on assessments, time and date of fall, and notifications, these areas were completed, however there are areas on this form that are left blank, such as, MD notification, Investigation completed, and Date of QA review, these areas are blank. This document was signed by V1(Administrator).

3. R3's "New Admission Sheet" documented R3's initial admission date to facility as 1/11/2024. R3's Physician Order Sheet documents diagnoses including Gastrointestinal Bleed, Abdominal Mass, Adenocarcinoma, and Metastatic Mass.

R3's Minimum Date Sheet (MDS) dated 1/26/2024 documents R3 has a Brief Interview for Mental Status (BIMS) score of 13, indicating R3 is cognitively intact. The same MDS in section GG

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S9999	Continued From page 14 documents that R3 requires ambulation with a walker and a wheelchair and self-care is noted as independent. R3's Fall Risk Assessment sheet in the medical record documented an assessment dated 1/11/2024 and documents a score of 9. The document instruction notes that "10" points or more = High Risk Score, indicating that R3 is not considered a "High Fall Risk." There were no other assessments documented on R3's Fall Risk Assessment sheet. Despite the fact that he had multiple falls documented on 1/24/24, 1/26/24, 1/27/24, and 1/31/24 the fall assessment completed on 1/11/2024, which is the only assessment completed, has under history of falls 0, which leaves the score as a 9 which is not considered a high fall risk. R3's "Skilled Progress Note" notes on 1/24/2024 at 10:45 AM, R3 was seen getting up from wheelchair to walk across the hall, he lost his balance and fell face hit the doorframe, he landed on right side. Has a small cut on bridge of nose, red area on left cheek. At 12:15pm during neuro (neurological) check noted more confusion and slurred speech. Resident (R3) complained of right arm shoulder pain and dizziness. Sent R3 to ER (Emergency Room) for evaluation. Ambulance service called. R3 taken to the hospital at 12:45pm. New orders for Magnesium Oxide and Potassium Chloride. Right sided weakness noted, V11 (Medical doctor) faxed of R3's (con) condition and (NO's) new orders. R3's local hospital Emergency Department (ED)	S9999		

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S9999	Continued From page 15	S9999		

records dated 1/24/2024 documented R3 had a recent stroke that was approximately a week old. The hospital records from hospital were reviewed and CT (computed tomography) scan that was performed on 1/24/2024 reads as, Impression: There is no intracranial stenosis or signs of acute vascular occlusion nor intracranial aneurysm or vascular malformation. The HPI (history of present illness) reads on 1/24/2024 at 16:29 (4:30 PM) "This 72-year-old white male presents to ED via EMS (Emergency Medical Service) with complaints of signs and symptoms of possible stroke. Patient (R3) fell out of a chair today, patient (R3) is saying that he has a weakness on the right side for about a week, also his speech is not clear. He has appointment with oncologist tomorrow regarding his adenocarcinoma of the rectum and thinks that patient (R3) will not have any therapy due to mental status of this disease, but she is not sure yet what she and her father will decide about it, waiting on oncologist opinion." R3 returned to the facility at 1900 (7:00 PM) with new orders for Magnesium and Potassium due to abnormal labs. R3 had a recent stroke that was approximately a week old. R3 returned to the facility that evening with new orders for Magnesium and Potassium due to abnormal labs. R3 had a recent stroke that was approximately a week old. There was no documentation in the hospital records of injuries sustained from the fall.

On 2/22/2024 at 1012AM, the fall packet and investigation were requested from V1 and again on 2/22/2024 2:00PM from V2. There was no fall packet or investigation provided from V1 or V2 for review during the survey.

R3's "Skilled Progress Note" on 1/26/2024 at 4:30

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S9999	Continued From page 16 AM documents: Heard voice found R3 sitting on floor near doorway leaning against nightstand and trash can. R3 has small skin tear above right elbow. R3 stated that he was going outside. 1-1 right time of day dark outside. R3 voiced understanding. Denies need for care but also agrees to call for assist when wants to get up and walk and get into wheelchair. R3's "Skilled Progress Note" on 1/27/2024 at 4:30 PM documents: R3 was noted laying on his back on the floor in his room. R3 stated he does not know why he got up from bed. No injuries found on R3. Able to move all extremities the same as prior to fall without pain. No shortening or rotations of lower extremities. Denied hitting head. No evidence of head injury noted. Assisted with gait belt and assist x2 to wheelchair. All parties notified of incident. Vital signs 98.9-108-20-120/76. R3's "Post Fall Root Cause Worksheet" dated 1/27/2024 documents as a heading "Bring Chart/Care plan/ 24-hour report." Under the heading of number 10 of this document, "Assess fall location for potential contributing factor, circled call light "off", and "noncompliance with safety reminders". Number 18 on this document's states Safety Measures and Interventions: "call light, floor mat, low bed, call don't fall sign. The question listed as: "Were all care plan interventions carried out?" Marked "yes". The worksheet has a designated area for Root Cause Analysis, this area was left blank. This document also has a question that states, "what interventions to prevent another fall need to be implemented today?" Written answer to this question is documented " Nonskid socks at all	S9999		

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S9999	Continued From page 17	S9999		

times". Next written question is "Why this Intervention?" Documented: "To prevent feet sliding."

R3's "Skilled Progress Notes" for 1/31/2024 document that at 10:10 AM R3 was observed on the floor next to bed. R3 states he slid off bed trying to get up, assessment done no s/s (signs/ symptoms) injury, denies hitting head, assist back to bed, nonskid strips applied to floor next to bed for fall prevention.

The "Quality Care Reporting Form" for R3 dated 1/31/24 The documents the time of fall, assessment, notifications, and vital signs. A specific area of this document was titled "Investigation Completed date" was left blank. Another area was titled "Date of QA Review date" was also left blank. The area of this document titled "Summary of event and any action taken" documented "Non-Skid Strips applied to bedside". This document is signed by V1.

R3's "Investigation Report of Falls "dated 1/31/24 in the section that is titled "Observations" it documents "was (R3) wearing adequate footwear?" with a documented response of "No socks on." The section "Completed by and date " at the bottom of the document, was missing a date.

R3's Fall Risk Assessment sheet in the medical record documented an assessment dated 1/11/2024 and documents a score of 9. The document instruction notes that "10" points or more = High Risk Score, indicating that R3 is not

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S9999	Continued From page 18 considered a "High Fall Risk." There were no other assessments documented on R3's Fall Risk Assessment sheet after R3's documented falls on 1/24/24, 1/26/24, 1/27/24, and 1/31/24. R3's Care Plan dated 1/18/2024 documented in the Fall section interventions listed, "Call Don't Fall" sign in room, Nonskid socks at all times, and soft mat in floor by bed. These interventions all fell under the date of 1/18/2024. No new interventions noted past that date. On 2/21/2023 an observation of R3's room was conducted to validate all intervention indicated on the Plan of Care dated 1/18/2024, were in place. "Call Don't Fall" sign was on the wall beside R3's bed. Nonskid strips were beside the bed on the floor. The Plan of Care documents that R3 has a soft mat beside the bed, a soft mat was not located in the room. The facility document dated 11/10/18 titled, "Fall Prevention" documents: Procedure: 1. Conduct fall assessments on the day of admission, quarterly, and with a change in condition. 5. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. 6. The unit nurse will place documentation of the circumstances of a fall in the nurses notes or on an AIM (Assess, Intercommunicate, Manage) or Wellness form along with any new intervention deemed to be appropriate at the time. The unit nurse will also place any new intervention on the CNA	S9999		

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S9999	Continued From page 19 assignment worksheet. 7. Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed in the Morning Quality Assurance meeting and any new interventions will be written on the care plan. The facility document dated 07/01/12 titled, "Notification for Change in Resident Condition or Status" Procedure: 1. The nurse supervisor/change nurse will notify the resident's attending physician or on call physician when there has been: a. Any symptom, sign or apparent discomfort that is: 1. Sudden in onset, 2. A marked change 3. Unrelieved by measures already prescribed. B. An accident or incident involving the resident; c. A discovery of injuries of an unknown source; h. A need to transfer the resident to a hospital/treatment center. "A"	S9999		