STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0048934	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY REHAB & HCC	**3298 RESOURCE PARKWAY , DEKALB, Illinois, 60115**

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S0000	Initial Comments Annual Licensure and Certification Complaint Investigations: 2518148/2600114 2518265/2605216 2518023/2600731	S0000		09/29/2025
S9999	Final Observations Statement of Licensure Violations 1 of 3: 300.615e) 300.615j) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information. e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) j) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based background check are pending; while the results of a request for waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending. These requirements are not met as evidenced by:	S9999		09/29/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0048934	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/05/2025

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S9999	Continued from page 1 Based on interview and record review the facility failed to obtain name-based Criminal History Background Checks within 24 hours of admission for seven residents (R2, R9, R19, R27, R51, R62, R76) of 10 residents reviewed for resident pre-admission background checks in the sample of 48. The findings include: Electronic Medical Record Census Reports indicate: R2 was admitted to the facility on 7/10/25. R9 was admitted to the facility on 8/12/25. R19 was admitted to the facility on 8/8/25. R27 was admitted to the facility on 8/18/25. R51 was admitted to the facility on 8/14/25. R62 was admitted to the facility on 8/18/25. R76 was admitted to the facility on 8/26/25. State Name-Based Criminal History Record background check inquiries for all seven residents (R2, R9, R19, R27, R51, R62, R76) were not completed until 9/2/25 (as dated on the reports receive from the State Police Agency). Criminal History Record responses received on 9/2/25 indicates R2 and R9 were identified as potential identified offenders. On 9/4/25 at 3:10pm V6, Regional Director of Operations stated, "We didn't realize the name-based inquiries had not been done until we were going through resident background checks on 9/2/25, so the inquiries were immediately sent out that day." V6 stated they should have been submitted when the other background checks were completed (prior to admission). The two residents that were then identified as possibly being Identified Offenders (R2 and R9) are now scheduled for finger printing. V6 stated R9 was already in a private room and R2 was moved temporarily to a private room until the fingerprint results are completed. (c) Statement of Licensure Violations 2 of 3: 300.610a)	S9999		

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S9999	Continued from page 2 300.1210b) 3001210d)1) 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. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. These Regulations are not met as evidenced by: Based on observation, interview and record review the facility failed to ensure chemical restraints were not utilized to manage behaviors in one resident (R37) with a diagnosis of Dementia and failed to obtain informed consent to administer psychoactive medications for two residents (R11, R37) of 5 residents reviewed for unnecessary medications in the sample of 48. This failure resulted in R37 becoming excessively sedated with difficulty speaking, eating/drinking and becoming dehydrated requiring intravenous fluids.	S9999		

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S9999	Continued from page 3 Findings include: 1. Current Physician Order Summary Report indicates R37 is 89 years old and has diagnoses that include Unspecified Dementia without Behavioral Disturbance, Psychotic Disturbance and Anxiety; Anxiety Disorder, and Depression. Order Report indicates R37 has orders for the following psychotropic medications: Gabapentin (anticonvulsant) 100mg (milligrams) three times per day for Dementia, Behavioral Dysregulation, Affective Instability (date initiated 8/7/25). Mirtazapine (antidepressant) 15mg at bedtime for depression/appetite stimulant related to Unspecified Dementia (date initiated 8/6/25). Report indicates Mirtazapine was increased from 7.5mg to 15mg per day on 8/6/25. Quetiapine (antipsychotic) 12.5mg every morning for Dementia without behaviors (date initiated 8/7/25). Quetiapine (antipsychotic) 25mg every evening for Dementia without behaviors (dated initiated 8/7/25). Comprehensive Cognitive Assessment dated 8/7/25 indicates R37 is severely cognitively impaired. On 9/2/25 at 10:15am R37 was brought from the dining room to V27, LPN (Licensed Practical Nurse) due to being difficult to arouse. R37 was sitting in a wheelchair with her head down - chin to chest. It took several attempts by staff loudly yelling R37's name and gently rubbing R37's arm to get R37 to briefly raise her head, eyes still closed, to minimally respond. V27 took R37's vital signs and oxygen saturation level and all were within normal limits. During the entire assessment R37 remained with her head down and eyes closed. V27 stated she notified V14, NP (Nurse Practitioner) who ordered a urinalysis to rule out a UTI (Urinary Tract Infection). On 9/2/25 at 12:40pm R37 was in her room and was being fed by staff. R37 remained slow to respond and ate only her ice cream and few bites of solid food. R37 did not try to feed herself. On 9/3/25 at 9:25am R37 was sitting in the dining room during breakfast meal. Psychomotor retardation was noted as evidenced by slowly lifting a cup to drink, no effort to use utensils to eat the food on her plate and	S9999		

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S9999	Continued from page 4 at times just sitting with her eyes closed. R37 would intermittently open her eyes when staff were nearby and encouraging residents to eat. On 9/3/25 at 10am R37 was sitting at a table with one other resident in the activity room. R37 was sitting with her head down and her eyes closed. On the table in front of R37 were coloring pencils, paper and a cup of juice. R37 made no effort to lift her head, use supplies provided or drink from the cup. At that time, R37's name was called loudly several times before R37 slowly lifted her head, without opening her eyes, and with a soft whispering voice stated "What." R37 was asked if she was "Ok" to which R37 responded (without opening her eyes) "My legs are stiff. I can't move." R37 was then seen trying to move her legs, however she was unable to move her legs and feet more than a few inches in either direction. On 9/3/25 at 10:10am V32, Activity Instructor was sitting near R37 in the activity room. V32 stated R37 is "usually not like this." V32 stated R37 usually moves herself around with her feet while sitting in the wheelchair "(R37) goes all over." V32 stated R37 can eat and drink without assistance. V32 stated "I think it's the medicine they're giving her." On 9/4/25 at 10:50am R37 was sitting in her wheelchair across from the nurses station with her head down - chin to chest, eyes closed and making no attempt to move. Psychiatry Note dated 8/7/25 indicates Chief Complaint for the visit was "increased crying spells and emotional lability." Note indicates due to reports of R37 having increased emotional lability (tearfulness/wandering), Mirtazapine would be increased (from 7.5mg to 15mg) and Gabapentin 100mg three times per day would be started to target mood and behavioral symptoms. On 9/4/25 at 11:45am V14, NP stated she saw R37 in the morning of 9/2/25 because staff were concerned about R37. V14 stated she was unaware at that time that R37 had been prescribed Gabapentin by the Psychiatric Nurse Practitioner and that R37's Mirtazapine had been doubled. V14 stated that starting R37 on 300mg of Gabapentin per day is an excessive dose for a resident of that age and size. V14 stated that (the Gabapentin) was "too much for (R37)" and that R37 is over sedated and would get the Gabapentin discontinued immediately. V14 stated R37's urinalysis was negative for UTI, so her sedation was not due to an infection.	S9999		

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S9999	Continued from page 5 On 9/4/25 at 1:50pm V14 stated she contacted the psychiatry service who prescribed the Gabapentin and they stated they ordered it as "Prevention." V14 stated "And in the mean time (R37) could barely breathe." NP Progress Note dated 9/4/25 at 4:36pm indicates R37 is very sleepy; has been on heavy psychiatric medications which have caused excessive sleepiness and decreased food and fluid intake. Recent labs show a significant decline in R37's renal function. Note indicates "These changes indicate worsening renal function due to dehydration." Note indicates IV (Intravenous) fluids initiated to improve renal function. On 9/4/25 at 11:05am V2, ADON (Assistant Director of Nursing)/Psychotropic Medication Nurse stated the only behaviors she was aware that R37 displayed were "crying alot", displays of sadness, history of delusions associated with Dementia and some sleep disturbance. V2 stated R37 never displayed aggressive behaviors or self harm. V2 stated R37 normally roams around in her wheelchair throughout the facility. V2 stated she was initially unaware that the Gabapentin was ordered for R37's mood/behavior so she never obtained consent. V2 stated that Gabapentin has been discontinued (since 9/4/25) due to R37's change in condition and is now getting IV fluids for dehydration. Pharmacy Recommendations dated 8/21/25 indicates pharmacist was unable to locate a signed consent for Gabapentin prescribed for R37 on 8/7/25. R37's current Care Plan indicates R37 has mood problems related to Dementia and is receiving antipsychotic and antidepressant medications. Care Plan indicates Mirtazapine increased on 8/7/25 due to increased episodes of tearfulness. Care Plan does not include addition of Gabapentin on 8/7/25. R37's Care Plan does not identify specific target behaviors requiring the use of psychotropic medications. 2. R11's face sheet showed last admission date of 12/20/2024 with a past medical history not limited to delusional disorders, anxiety disorder, and psychotic disorder with delusions due to known physiological condition. Minimum Data Set (MDS) Section N for medications dated 06/24/2025 documented that R11 “is taking antipsychotic medications that were received on a routine basis.”	S9999		

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S9999	Continued from page 6 R11's care plan with last completion date of 06/26/2025 reads in part: has mood problem: anxiety, delusional disorder and hallucinations related to Parkinson's and is receiving antipsychotic medication. R11's care plan interventions included, but not limited to: administer antipsychotic medications as ordered by medical doctor, monitor/document for side effects, adverse reactions and effectiveness and to educate the resident/family/caregivers regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation, maintenance. R11's consulting pharmacy note dated 08/21/2025 indicated to "see report for recommendation." Nursing recommendations for R11 provided by facility on 09/04/2025 from the consulting pharmacist that was dated 08/22/2025 documented, "upon review of resident's record, I was unable to locate a signed consent or documentation of verbal consent for sertraline 25mg (milligrams)" new as of 08/06/2025 and recommended facility to either obtain consent or add to R11's medical record if already received. R11's active physician orders as of 09/04/2025 showed orders for the following psychotropic medications: quetiapine fumarate 25mg (milligrams) give 0.5 tablet by mouth in the morning related to psychotic disorder and sertraline 25mg tablet by mouth one time a day related to generalized anxiety disorder. Both medications showed start dates of 08/07/2025. (Requested physician's order summary but was not provided by facility). On 09/04/2025, review of R11's medical record by surveyor showed no signed consent or documentation of verbal consent for the sertraline 25mg on file. Review of R11's medication administration records for August 2025 through current showed R11 received this medication daily with a start date of 08/07/2025. On 09/04/2025, the facility provided two consents for psychotropic medication therapy for R11's quetiapine dated 02/25/2024 and 06/24/2025. No consent was provided for sertraline 25mg. On 09/04/2025 at 03:00 PM, V2 (Assistant Director of Nursing) said informed consent should be obtained prior to starting any psychotropic medication to ensure the resident and/or representative understand why the resident was prescribed the medication along with the risks/benefits associated with the medication.	S9999		

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S9999	Continued from page 7 Facility Policy/Psychotropic Medication Use dated 2/2025 documents: Residents will only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Prior to starting psychotropic medications, informed consent will be obtained from resident/representative per state guidelines.Facility Policy/Behavioral assessment, Intervention and Monitoring dated 12/2024 documents: Non-pharmacologic approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms. (B) Statement of Licensure Violations 3 of 3: 300.610a) 300.1210b) 300.1210c) 300.1210d)2) 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	S9999		

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S9999	Continued from page 8 supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. These Regulations are not met as evidenced by: Based on observations, interview, and record review the facility failed to obtain daily weights for a congestive heart failure resident (R52). This failure resulted in R52 gaining 60 pounds in one month and requiring hospitalization. The facility also failed to ensure follow-up care was completed after a resident fell (R60). This applies to 2 of 5 residents (R52, R60) reviewed for quality of care in the sample of 48. Findings Include: 1.On 9/2/25 at 10:22 AM, R52 was seated in a bariatric wheelchair with oxygen in place at 4 liters per nasal canula. R52 was able to speak, but did get short of breath during the interview. R52 stated, “I’m sick of this fluid. I’ve gained over 43 pounds, and it just seems to keep going up.” R52 said the facility does weigh her, but she doesn’t think it’s every day. R52 said she has been seen in the past by Cardiology for issues with fluid retention. R52 was obese and had generalized edema noted. R52 said she was on a “water pill” and the facility had added another recently. At 12:30 PM, R52 was seated in her wheelchair in the dining room, feeding herself a grilled cheese sandwich. R52 started coughing and placed her hand on her chest. The surveyor asked R52 if she was okay and replied, “Yes, I think I just have too much mucous in my chest.” R52 ate some more of her meal. At 1:02 PM, V10 (Agency Licensed Practical Nurse) pushed R52’s wheelchair back to her room. R52 slid her butt toward the seat of the wheelchair to provide more mobility between her abdomen and chest. V10 provided breathing treatments and notified V14 (Nurse Practitioner). V14 went in room see R52.	S9999		

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S9999	Continued from page 9 R52's Hospital Admission Record dated 9/2/25 showed she came to the hospital with shortness of breath that started 3 days ago. The patient reported increased lower extremity swelling and possibly 60-pound weight gain. Due to worsening shortness of breath, she was sent to the emergency room. The patient does report some chest pain along with some productive cough with phlegm. On arrival her oxygen saturation was 89% on room air and she was placed on an open mask. The patient's troponin (cardiac marks for heart tissue damage) was negative and her BNP was normal. This document showed R52's chest x-ray showed mild pulmonary edema. The document showed R52 was admitted with acute on chronic respiratory failure with hypoxia, acute asthma exacerbation, volume overload versus CHF (Congestive Heart Failure) exacerbation, and morbid obesity. This document showed the plan to treat R52's volume overload was strict intake and output, daily weights, intravenous diuretics, and cardiology consult. R52's Facesheet dated 9/3/25 showed diagnoses to include but not limited to acute on chronic respiratory failure with hypoxia, moderate persistent asthma, severe morbid obesity, CHF, Chronic Obstructive Pulmonary Disease (COPD), weakness, lymphedema, need for assistance with personal cares, dysphagia, generalized anxiety disorder, and peripheral vascular disease. R52's Physician Order Sheet dated 9/3/25 showed an order for "Daily weights in the morning," to start 8/21/25. On 8/1/25, the resident weighed 486.6 lbs. On 9/1/25, the resident weighed 548.4 lbs which is a 12.7% Gain (61.8 pounds). R52's Weight report was missing daily weights on 8/22, 8/23, 8/24, 8/26, 8/27, 8/28, 8/30. R52's weight on 9/1/25 was 548.5 pounds and she showed a 5.4 weight loss on 9/2/25 (weight was 543 pounds). R52's August Medication Administration Record (MAR) did not contain any daily weights. R52's Progress Notes were reviewed on these dates and there was no documentation of refusals. R52 was seen by the V14 (Nurse Practitioner) on 9/2, 9/1, and 8/27. R52's Progress notes showed had a pulmonary consult on 8/25/25. On 9/3/25 at 11:50 AM, V11 (Wound Care Nurse) said she had several roles at the facility. V11 said one of those roles was doing post-acute work and working to	S9999		

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S9999	Continued from page 10 prevent rehospitalizations. V11 said R52 had several chronic health issues, and she can be non-complaint with diet and fluids. V11 said R52 has severe CHF but has the mindset that she can eat and drink as she pleases and go to the hospital to get intravenous medications to remove excess fluid. Then she feels better, and we start all over. V11 said the V15 (Previous DON – Director of Nursing) was responsible for following the weights. V11 said now she is just making sure the weights are done. V11 said the weights should be obtained as ordered by the provider. V11 said daily weights are important for CHF residents to ensure there is no fluid overload and/or tracking the progress of our interventions. The surveyor asked if the order should include when to call the Provider. V11 looked at the order and replied, “We have a standing order for CHF.” V11 said if the resident gained 2-3 pounds overnight or 5 pounds in a week, then the nurse should notify the Provider. V11 said special cases like V11, the resident may gain weight at a faster rate. The surveyor asked V11 to view R52’s Electronic Medical Record (EMR). V11 said there is no good reason those weights shouldn’t be charted, unless she refused. V11 said if R52 refused then there should be a progress note that she refused to be weighed. V11 said she didn’t see any progress notes showing that R52 refused to be weighed on 8/22, 8/23, 8/24, 8/26, 8/27, 8/28, and 8/30. V11 said the CNA or nurse can obtain the weight. V11 said the weight should be charted in the EMR and the nurse should be checking for trends. V11 said she didn’t know why that wasn’t happening. V11 said on 9/2/25, V12 (Respiratory Therapist) came to assess R52, and they got the order to transfer her to the hospital. V11 said R52 was admitted to the hospital for shortness of break. V11 said the facility was aware there was a problem with these weights, and they are working on this issue. On 9/3/25 at 3:14 PM, V10 (Agency LPN) said she only works at the facility every couple of weeks for 1-2 shifts. V10 said she works wherever she is needed, so she doesn’t have a consistent assignment. V10 said the weights should be taken by the CNA and the nurse enters the weights. V10 said the nurse should be following the physician’s orders for daily weights and monitoring for changes. V10 said the nurse should notify the Provider if there is a greater than 3-pound weight gain in 1 day and 5 pounds in a week. V10 said she didn’t work for the last week, so she didn’t know if anyone looked at the weights. V10 said the nurse should have been making sure the daily weights were completed and reporting weight gain. V10 said she didn’t realize R52 had gained so much weight. V10 said weight gain can be a sign of	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY REHAB & HCC	**3298 RESOURCE PARKWAY , DEKALB, Illinois, 60115**

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S9999	Continued from page 11 fluid retention and could have contributed to R52's breathing issues. V10 said she was R52's nurse on 9/2/25 and R1 was complaining of shortness of breath in the morning, but her vital signs were stable. V10 said R1's oxygen saturation was 89-90% on 4 liters per nasal cannula. V10 said she did assessments and she was stable. V10 said after lunch she started to get a little worried and gave her breathing treatments. V10 said she notified V14 (NP). V10 said V14 assessed R52 and said she didn't need to go to the hospital at this time. V10 said a few hours later V12 (Respiratory Therapist) did an assessment, and it was decided to send R52 to the hospital for shortness of breath and she started to complain of some chest pain. R52 was starting to lean back in the wheelchair to breath better. On 9/3/25 at 10:23 AM, V14 (NP) said she works at the facility Monday through Friday. V14 said R52's case is very complicated, and she has several comorbidities. V14 said on 8/20/25 she ordered daily weights to track R52's fluid balance. V14 said R52 gained 60 pounds in 6 months, so I thought it was important we get the daily weights on track. V14 said when she orders a daily weight, she expects the order to be followed. V14 said R52 was already on Bumex (a diuretic medication) twice a day so she consulted a Pulmonology. V14 said they were discussing R52's case because she was having more difficulty breathing and felt like she was retaining fluid. V14 said she started R52 on Spironolactone, ordered a bladder scan, and labs. V14 said R52 reported she didn't feel like she was urinating enough, so we started Flomax. She was gaining weight, but on 9/1/25 (the day before she went to the hospital) she was being noncompliant with her fluid restriction, and I had to have a discussion with her. V14 said she ordered Strict Intake and Output for her on 9/1/25 and an Echocardiogram (doppler ultrasound of the heart). V14 said she was trying to explain to the resident that she needs to allow time for the interventions to help, but the resident does have times where she was non-compliant. V14 said V10 (LPN) called me on 9/2/25 and wanted to send her to the emergency room. V14 said she did an assessment and had a conversation with R52, and she didn't feel it was necessary to transfer at that time. V14 said she felt R52 needed to allow time for interventions, but when she started to complain of chest pain. The decision was made to transfer her to the emergency room. V14 said she checked R52's hospital record and she was admitted for shortness of breath, respiratory failure, and CHF. V14 said the daily weights are important part of R52's chronic disease management, but not the only part. V14 said if a daily weight is ordered, it needs to be done. V14 said if the	S9999		

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S9999	Continued from page 12 staff are not doing the weights, then she would expect them to explain why and report it to her. V14 said if R52's weights were done as ordered and interventions were performed sooner it's possible the outcome could have been better, but it's hard to know for sure. V14 said R52 had lost weight the last day and she felt the interventions were starting to work. V14 said R52 needed intravenous medications to manage her fluid status at this time. V14 said she agreed that there was an issue with her weights. V14 said her expectation are higher than some others, but when it comes to human life it should be. The facility did not have a policy for obtaining weights for CHF patients or following physician's orders. The facility provided a Care Path Symptoms of Heart Failure diagram. This diagram showed that symptoms or signs of HF included unrelieved shortness of breath or new shortness of breath at rest, unrelieved or new chest pain, wheezing or chest tightness, inability to sleep without sitting up, weight gain or 3 pounds in 3 days or 5 pounds in 7 days, and worsening edema. This diagram showed if oxygen saturations were less than 90% (in addition to the above listed symptoms) then they should notify the Provider. 2. R60's Final Fall Report dated 7/28/25 showed R60 was placed in the TV room directly across the hall from the nurses' station. This report showed that R60 has agitation and restless and a non-pharmacological intervention includes placing her in quiet area with TV to promote a decrease in behaviors and calm the resident. This report showed R60 was reaching for the TV remote and fell onto her left side. A head-to-toe assessment was complete and R60 was noted with left shoulder pain and an order for X-ray was placed. The X-ray results showed a left clavicle fracture. This form showed R60's physician and hospice were notified of the results and splint was placed for immobilization and pain management orders were adjusted. The resident's pain is being controlled and resident wishes to remain in the facility. On 9/2/25 at 11:43 AM, R60 was sitting up in reclined wheelchair. R60 was moving her arms and feeding herself with no difficulty. R60 was no longer wearing a sling to her left arm. R60's Facesheet showed diagnoses to include, but not limited to primary generalized osteoarthritis, chronic kidney disease, hypothyroidism, dysphagia, left clavicle fracture, dementia, generalized anxiety	S9999		

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S9999	Continued from page 13 disorder, macular degeneration, peripheral vascular disease, and stroke. R60's Physician's Order Sheet showed an order was placed for a 2 view Xray of the shoulder due to pain from a fall on 7/26/25. These orders showed an order for an external splint to left shoulder if pain noted was entered 7/28/25. R60's Progress Note dated 7/26/25 at 10:12 PM showed R60 fell out of her chair and complained of left shoulder pain during assessment and an X-ray was ordered for Monday. (2 days later). The notes showed did not show evidence that the facility called to check the status of the Xray. R60's progress notes on 7/27/25 showed R60 was experiencing pain, had bruising to the left shoulder, and had limited range of motion to the left arm. These notes showed that R60 was treated for pain, but did not have the sling in place, nor had the Xray been completed. On 7/28/25, R60's X-ray results were reported to the physician and orders for a sling were obtained for additional support. R60's Left Shoulder Xray Report dated 7/28/25 showed an acute displaced fracture of the left clavicle. On 9/2/25 at 2:01 PM, V15 (previous Director of Nursing – DON) said she was notified R60 fell out of her chair on 7/26/25. V15 said she did the investigation on Monday (7/28/25) and she called X-ray to follow-up because they hadn't come yet for the Xray. V15 said the Xray order was placed for Monday and R60 shouldn't have had to wait that long. V15 said V18 (Agency RN) didn't place a stat order, and they didn't ensure the X-ray was completed or the sling order was obtained in a timely manner. V15 stated, "Just because [R60] is on hospice doesn't mean we don't treat people." On 9/4/25 at 10:40 AM, V14 (Nurse Practitioner) said she wasn't here when R60 fell, but if she fell directly on her left side and complained of pain an X-ray order should have been entered to be done immediately. They shouldn't have waited until Monday. That's a delay of care. V14 reviewed R60's chart and said she already had pain medication on board, but it looks like the sling wasn't ordered until after the Xray results. V14 said the facility should have ensured Xray was ordered immediately, completed within 24 hours, and the interventions were placed. V14 said it's important to make sure the fracture isn't displaced or puncturing something. V14 said based on R60's injury there isn't much they can do for her. V14 said R60's care would be more conservative, but it was important to get the Xray results timely.	S9999		

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S9999	Continued from page 14 The facility's policy and procedure approved 12/2024 showed, "Fluid Restriction, Policy: Only those resident's that have a practitioner's order will be on fluid restriction. Procedure: 1. Verify medical practitioner order. 2. Notify dietary consultant of order for fluid restriction… 3. Remove the resident's water pitcher and cup from the room. Store in designated area…" (B)	S9999		