

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058206		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/07/2026	
NAME OF PROVIDER OR SUPPLIER ACCOLADE HEALTHCARE OF SAVOY				STREET ADDRESS, CITY, STATE, ZIP CODE 302 WEST BURWASH , SAVOY, Illinois, 61874			
(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) COMPLETION DATE	
S0000	Initial Comments Complaint 2663307 /IL 2808213 Facility Reported Incident #2963715 of 03/08/26		S0000				
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.1210d)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 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:		S9999				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 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. THESE REQUIREMENTS WERE NOT MET EVIDENCED BY: Based on observations, interviews and record review, the facility repeatedly failed to maintain a safe environment for residents at risk of falls. These failures affected four residents (R2, R3, R8 and R9) of six residents, which were reviewed for falls/environment, on the sample list of nine residents. R3's fall from an elevated bed with a slick surfaced air mattress, resulted in a Right Humerus, Acute Moderately Displaced Spiral Fracture of the Mid Humeral Diaphysis (main shaft of the bone) that required hospitalization. Findings include: 1. R3's current Diagnoses Sheet documents the following: Secondary Malignant Neoplasm of Liver, and Intrahepatic Bile Duct, Secondary Malignant Neoplasm of Right Lung, Secondary Neoplasm of the Bone, Neoplasm Related Pain (Acute), Chronic, Chronic Obstructive Pulmonary Disease, Unspecified, and Anxiety, Unspecified. R3's Minimum Data Set (MDS) dated 2/14/26 (prior to R3's fall with fracture on 3/8/26) documents the following: R3's Brief Interview of Mental Status (BIMS) score of 11, which indicates R3 has moderate cognitive impairment and has "Behavior present, fluctuates (comes and goes, changes in severity) of Inattention - Did the resident have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said." R3's MDS also documented the following Activities of Daily Living (ADL's) prior to R3's fall 3/8/26 as follows: Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunks or limbs, but provides less than half the effort. This assistance is needed to roll left and right, sit to lie, lie to sit on the side of the bed, sit to stand, and chair/bed-to-chair transfer. The same MDS prior to a fall with fracture document:		S9999				

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S9999	Continued from page 2 R3 is "Dependent - Helper does ALL the effort. Residents do none of the effort to complete the activity, or the assistance of 2 (two) or more helpers is required for the resident to complete the activity" for ambulation and uses a manual wheelchair and walker for mobility. R3's same MDS documents. R3 is frequently incontinent of bladder and always incontinent of bowel. R3's Fall Risk assessment dated 2/27/26 documents that R3 was at moderate risk for falls (prior to R3's fall on 3/8/26). R3's current Care Plan documents the following: R3 is at risk for falls related to Deconditioning, Gait/balance problems. Date Initiated: 09/30/2025. Interventions include: • Non-skid socks- when the resident will allow. Date Initiated: 02/27/2026. • Resident observed with bed in the air, bed remote in hand after trying to lower bed, resident declined and continued with remote in hand; education provided. (The above MDS documents R3 was cognitively impaired and had Initiation in tracking information). Date Initiated: 02/09/2025 (Before R3's fall with fracture) - Anticipate and meet the residents' needs. Date Initiated. 9/30/25. • Be sure the resident's call light is within reach and encourage the resident to use it as assistance as needed. The residents' needs, prompt response to all requests. Date Initiated: 09/30/2025. - R3's same Care Plan documents on "3/8/26- remove LAL (Low Air Loss Mattress). Date Initiated: 03/08/2026 (post fall). • 3/8/26- sent to the ER for evaluation • 3/9/26- education (after fall 3/08/26, per MDS above, R3 has moderate cognitive impairment and has Inattention behaviors) on lowering the bed while in the bed; resident requests to keep the bed remote in reach and adjust as he prefers, including the height of the bed. education on risks, dangers, and injury. Date Initiated: 03/09/2026 • 3/9/26- sign placed to encourage use of call light.			S9999			

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S9999	Continued from page 3 Date Initiated: 03/09/2026. • Appropriate footwear. Date Initiated: 02/27/2026 • Call light within reach. Date Initiated: 02/27/2026 • Keep items within reach. Date Initiated: 02/27/2026 R3's "Fall with Major Injury Investigation" report and witness statements, dated 3/8/26 at 4:25 pm, document the following: R3's Transfer Status: (R3) requires substantial assistance with one staff member to get out of bed, along with assistance of one for bed mobility. (R3) requires assistance from one staff member for incontinence of care and personal hygiene, and can use the urinal independently with some incontinence of bowel and bladder. R3's same "Fall with Major Injury Investigation" report documents the following witness statements: Timeline of Events: It was documented on 3/08/26 at 3:10 pm that: V42 Certified Nursing Assistant/CNA stated that V42 arrived at 2:00 pm for V42's shift. V42 CNA reported observing R3 in bed at that time, the call light in reach with R3's bed at a reasonable height. While rounding at approximately 3:10 pm, V42 CNA stated, V42 completed incontinence care and lowered R3's bed back down, giving R3 the call light attached to R3's gown and bed remote (though R3 has moderate cognitive impairment and inattention according to the 2/14/26 MDS above), which was in R3's left hand. V42 CNA stated R3 moves R3's bed freely. V42 CNA stated that R3's urinal was at R3's bedside when V42 was leaving the room, and the table was to the right side for all frequently used items in reach. V42 CNA stated that during incontinence care, nonskid footwear was on. V42 CNA stated while leaving the room, V42 shut the door per the resident's request. It was documented on 3/08/26 at 4:20 pm that V53 CNA reported that V53 saw resident (R3) within 5 (five) minutes prior to fall. V53 CNA reports that (R3) was observed sitting on the side of the bed, and R3 was assisted back into bed. V53 CNA noted that R3's bed was raised to about waist level, bed control was beside R3, with call light at this time on R3's left side. The bedside table was on the right of R3. At that time V53 CNA attempted to meet the needs and see what R3 needed, R3 stated R3 was just sitting there, it was explained the lack of safety, R3 agreed. R3 is moderately		S9999				

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S9999	Continued from page 4 cognitively impaired and has a behavior of Inattention making it difficult to keep track of what is being said as noted above on R3's 2/14/26 MDS). R3 was positioned in a manner of comfort with call light across resident with bed remote to R3's left side, bedside table on the right side, urinal present in room. V53 CNA reported that R3 was not often wanting to get out of bed. V53 CNA reported that V53 was attempting to find a staff member on that hall to report that R3 was more active and was sitting on the side of the bed. It was documented on 3/08/26 at 4:25 pm by V17 Registered Nurse (RN): V17 RN reported hearing a call for help at which time V17 RN went to inquire about the calling. A visitor (unidentified) was observed pointing into the room of R3. V17 RN reported that upon entry to the room, R3 was observed laying on the right side of R3's bed, head toward the head of R3's bed, feet toward the foot of bed, lateral (laterally) to R3's bed on R3's right side. The floor was clear of debris and dry. The recliner was placed to the right of the bed; a wheelchair was closest to the bed (per family interviews and surveyor observation R3's wheelchair was consistently positioned across the room, on the opposite side of R3's recliner, approximately eight feet away) beside the recliner. Call light was observed on the resident, not engaged. The resident was clothed with a brief on, and non-skid socks were not on. V17 RN reported that R3 stated that R3 was attempting to get up and go to the wheelchair. V17 RN reported that V17 assessed R3 without an immediate sign of injury, R3 reported minimal pain while lying on the ground, no shortening or oration, or deformity to bilateral lower extremities. R3 stated that R3 did not hit R3's head; mention was at baseline, aox3 (alert and oriented to person, place and time). V53 CNA and V57 CNA were attempting to assist R3 with the full body mechanical lift at which time R3 appeared to have increased pain. V17 RN returned to the room and observed a noted deformity to R3's right upper arm. V17 RN reported it appeared that R3's arm was dislocated. V17 RN reported that an assessment of the right arm resulted in a positive radial pulse, with good temperature and pallor. V17 RN informed the CNA's not to move resident any further at which time V17 RN and V57 CNA made R3 as comfortable as possible with a pillow under R3's head and V57 CNA remained with R3 while the nurse started to call providers and EMS (Emergency Medical System). The ambulance arrived and administered pain medication and assisted R3 off the ground following their protocols. R3's same "Fall with Major Injury Investigation" report documents the following: During the investigation it was determined that general decline in health		S9999				

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S9999	Continued from page 5 contributed to this fall in conjunction with mild cognitive decline. R3 was observed on the ground laterally to the bed. R3 exclaimed that R3 wanted to get in the wheelchair and to another staff member wanted to walk. While R3 requires one staff assist to transfer, it was determined that R3 did not ask for help. While the call light was pinned to R3, it was found that R3 does not use R3's light often (see MDS cognitive on 2/14/26). A reminder sign was placed in eye view and return articulation observed with call light engagement. R3's same "Fall with Major Injury Investigation" report documents the following: During the investigation it was discovered that R3 adjusts R3's bed independently without insight (above MDS 2/14/26, Moderate cognitive impairment and inattention to track conversations) of risk relating to injury. While R3 has a prior intervention to wear nonskid socks, it was noted that R3 had socks on prior to the fall that they were not on at the time of fall. This was reviewed as contribution to the fall. R3 was interviewed and R3 stated that at times R3 does not want socks on and at times they just come off. Socks were reviewed with proper sizes observed. All frequently used items are placed in reach. R3's same "Fall with Major Injury Investigation" report documents the following: The interdisciplinary team reviewed the use of R3's low air loss mattress (LAL) supplied by Hospice. Due to the improvement of wound impairment with end-of-life care, it was determined that the removal of the low air loss mattress is appropriate. Due to the slick material and unsteadiness while sitting at the bedside, it was determined that while this was not the root cause it was a contribution. R3's same "Fall with Major Injury Investigation" report documents the following: "Due to all the factors that increase the risks for major injury, it is determined that the interventions placed will aid in the reduction of major injury. While some factors such as metastatic bone cancer raise risks for the resident (R3). The use of bed control alone did contribute to the risks; education used to reduce the risks. Due to the overall decline, resident (R3) is on hospice with a greater risk for further decline and risks. While there are risks, it is determined that encouragement of nonskid footwear and offering regularly to get up as residents have shown is lack of call light use. Along with the use of the reminder, it is anticipated to aid in reduced risks. (R3) continued to want comfort over all other treatment this includes reducing the risk for		S9999				

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S9999	Continued from page 6 further injury." R3's Hospital records dated 3/8/26 document the following: "HPI (History of Present Illness): (R3) is a (specified age) old male with significant PMH (Past Medical History) of poorly differentiated metastatic adenocarcinoma, who presented with a chief complaint of arm pain. Patient (R3) was recently admitted 2/14/26 through 02/26/2026 for pleuritic chest pain requiring pain medication titration. A decision was made during hospitalization to discharge to ECF (Extended Care Facility) on Hospice. The patient was brought in via EMS (Emergency Medical Service) from the ECF today, after a fall. Patient was seen and examined at bedside; (V55, Family Member) present as well. Patient states he (R3) has been doing well at the ECF and has gained some energy back after discharge. (V55) notes the first day he took Norco (narcotic pain medication) post-discharge, he (R3) was extremely tired but otherwise has been doing well with his pain medications. Patient (R3) was reportedly groggy today (3/8/26) and attempted to get out of bed and into his wheelchair. Patient (R3) typically knows that he cannot walk and should not be transferring by himself. Patient fell and landed on his arms. In the ED (Emergency Department), XR (X-Ray) right humerus shows an acute, moderately displaced spiral fracture of the mid humeral diaphysis (upper arm). Patient (R3) required IV (intravenous) ketorolac (anti-inflammatory medication used for moderate to severe pain) and morphine (narcotic medication treatment used for severe pain) due to intractable (difficult to control) arm pain. He (R3) is admitted to the hospital for further management. " On 4/3/26 at 2:25 pm, V39 Wound / Registered Nurse (RN), V42 and V43 Certified Nursing Assistants (CNAs) washed their hands and donned gowns and gloves before entering R3's room. R3 was lying in bed on R3's back. R3 had a brace on his right upper arm/shoulder. V39 RN stated R3 had been administered pain medication in anticipation of completing the wound dressing change. R3 stated R3's shoulder was fractured when R3 was trying to sit up on the side of R3's bed. R3 also stated "I (R3) had a different mattress at the time. Before, I (R3) could get to a seated position in bed, the air in the other mattress pushed me off the bed." R3 stated "The bed was too high and thrust me forward. My wheelchair was over there (points to the opposite side of the room) in the corner. I tried to stay on my feet but couldn't, so I reached towards my wheelchair and fell. I was tossed off the bed. That is all I remember. I can't say how long I was on the floor. My concept of time was skewed. My arm was hurting pretty		S9999				

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S9999	Continued from page 7 bad." On 4/3/26 at 4:25 pm, V2 Director of Nursing (DON) reviewed details of R3's fall with the humerus fracture on 3/8/26. V2 DON confirmed R3 is moderately cognitively impaired, has had a change in conditions and is currently on (end of life care services) Hospice. V2 DON also stated "(R3) had a low air loss mattress which was a contributing factor to his (R3's) fall. He (R3) had been seen sitting on the side of the bed prior to fall. He (R3) had attempted to get up to his wheelchair to go to the bathroom. The bed, from my understanding, was somewhat elevated and he had a low air loss mattress due to his history of pressure ulcers. The low air loss mattress apparently shifted as he went to sit up on the side of the bed. The air mattress then nudged him off the bed. He did not turn on his call light and request help. He (R3) did not have his non-skid socks on when he fell. They (non-skid socks) were on him prior but had come off in his bed. We put up a sign to remind him to ask for help. We removed the air mattress from his bed because it was a contributing factor in this fall." On 4/3/26 at 4:35 pm, V54 (R3's) Family Member, and V55 (R3's) Power of Attorney (POA) were interviewed at the same time. V54 was seated in a straight-back chair across from the foot of R3's bed. V55 was seated in R3's wheelchair next to R3's bed. R3 was asleep in bed. V54 stated V54, V55, and several other family members were visiting R3 the afternoon of R3's 3/8/26 fall. "We (R3's Family Members) were all here, from a little before 1:00 pm, until a little after 2:00 pm. We decided to go to lunch. When we all left. (R3) was in bed, asleep. (V55, Power of Attorney/Family Member) got a call about an hour or so later, saying (R3) fell. We came back to find (R3) on the floor and in a lot of pain." V55, then stated, "When I got the call from one of the nurses (unidentified) at the nursing home, I was told (R3) was lifted off his bed by the air mattress when he (R3) went to stand up to go to the bathroom. When we arrived, R3 was on the floor and had severe arm pain. The Paramedics showed up just before 4:00 pm. They took one look at (R3's) arm and said they were sure (R3's) arm was broken. While (R3) was on the floor, (R3) told me he was up, sitting on the side of the bed, and felt a push from his mattress. (R3) told me the air mattress thrust him to stand up, next to his bed. He (R3) said the bed was too high for him to stand up, so he attempted to go towards his wheelchair and fell." V55 also stated, "His (R3) recollection at that time, lying in pain, was very clear. Though he does have confusion at times. He was clear as a bell while waiting for the ambulance." V55 (R3's) POA and V54	S9999					

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S9999	Continued from page 8 (R3's) Family Member both stated that R3's wheelchair is not ever next to his bed. V55 also stated, "The CNAs (Certified Nursing Assistants) put it out of the way, across the room, next to (R3's) recliner in the corner. It was there every day when we came in. That is where it was when we left, the day he fell." V55 then stated, "I sit in it (wheelchair), next to (R3's) bed when I come in (seated in R3's wheelchair at the time of the interview). I get it (wheelchair) from up against the wall, next to the recliner every time. I put it back there, so it is not in the CNA's way. (V55 points across R3's room, approximately eight feet from R3's bed) That is where they say they want it. (V54 confirmed the area, eight feet from R3's bed, is where R3's wheelchair is placed routinely). He (R3) would never have made it that far on his own. He has gotten very weak since getting on Hospice." V54 and V55 both confirmed R3 does not use his call light, and they have not seen him change the level of the bed, but believe it is possible when he gets confused. V55 stated, "He may confuse that remote (bed device) with the TV (television) remote. He probably shouldn't have it (bed remote control device) in his bed." V54 and V55 both agreed they have seen CNAs raise his bed to change his incontinence brief and leave the room with R3's bed still elevated too high. V55 also stated she has lowered R3's bed several times before she leaves the facility. On 4/07/26 at 10:15 am, the V51 Hospice Nurse was standing at the side of R3's bed. V51 stated, "I (V51) was notified the night he (R3) fell. They had contacted the on-call Hospice service. I (V51) talked to several staff members in the facility the next day. I (V51) heard he (R3) tried to get out of bed. The facility said they felt like the air mattress was the reason for his (R3) fall. I (V51) asked for bedrails, and the (V2 Director of Nursing) said he (R3) would not pass the assessment. I have come into the facility several times and seen his (R3's) bed elevated to about this height (approximately four feet). I (V51) have let several staff know this should not happen. This is a big safety risk. His (R3's) bed mattress is new and has bolsters, which makes sense since bed rails are not an option for him." 2. R3 had a second safety event after the above fall with fracture, which is documented below. R3's current Diagnoses Sheet documents the following: "Subluxation of Other Parts of Right Shoulder Girdle, Subsequent Encounter, and Non-Surgical Orthopedic/Musculoskeletal.	S9999					

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S9999	Continued from page 9 R3's Minimum Data Set (MDS) dated 3/11/26 (after the fall with fracture 3/8/26) documents R3's Brief Interview for Mental Status (BIMS) score of 11, which indicated R3 had moderate cognitive impairment. The same MDS documents R3's Activities of Daily Living (ADLs) decline as follows: "Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort." for the following: Roll left and right, sit to lie, lie to sit on the side of the bed, sit to stand, and chair/bed-to-chair transfer. The same MDS documents the following: R3 is "Dependent - Helper does ALL the effort, residents do none of the effort to complete the activity. Or the assistance of 2 (two) or more helpers is required for the resident to complete the activity" for ambulation and requires a manual wheelchair for mobility." R3's "Fall with Major Injury Investigation" report dated 3/8/26 at 4:25 pm documents that R3 had a fall from an elevated bed with a low-air-loss mattress. R3's Hospital Records dated 3/8/26 document that R3 was admitted via the emergency room to the local hospital after a fall in the long-term care facility. The same hospital records document that R3 sustained a Right Humerus, Moderately Displaced Spiral Fracture of the Mid- Humeral Diaphysis (upper arm bone). On 4/1/26 at 12:10 pm, R3 was found lying in an elevated bed. The surface of R3's foam bed mattress was approximately three and a half feet above the floor. R3's wheelchair was across the room, sitting next to a recliner chair at the far corner (approximately eight feet) from R3's bed. There is a sign on the bathroom door directing R3 to use his call light for help. The bathroom door is approximately eight feet from R3's bed, on the opposite side of the room from R3's wheelchair. R3's call light cord was out of reach and was dangling off the bed frame at the head of R3's bed. R3's bed remote control device was also out of R3's reach. R3's bed remote control device was lying on top of the blanket, approximately six inches from the foot of R3's bed. R3 was pleasantly confused. R3 stated R3 did not understand why his bed was elevated and did not know how it got that way. R3 also stated R3 does not know if R3 had any falls, "You would have to ask the lady. I just woke up when the lady was in here checking to see if I was wet."			S9999			

Illinois State Department of Health

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NAME OF PROVIDER OR SUPPLIER ACCOLADE HEALTHCARE OF SAVOY				STREET ADDRESS, CITY, STATE, ZIP CODE 302 WEST BURWASH , SAVOY, Illinois, 61874			
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S9999	Continued from page 10 On 4/1/26 at 12:15 pm, V30 Certified Nursing Assistant (CNA) confirmed R3's bed was elevated, call light out of R3's reach and R3's bed control at the foot of R3's bed. V30 CNA stated to R3 "Your bed is way too high. We have got to make you safe." V30 CNA removed the bed control device from the foot of R3's bed. V30 CNA stated to R3, "Well it is obvious you did not put the bed up by yourself. You can't reach this (shows R3 the bed control device)." V30 CNA lowered R3's bed by approximately one foot. V30 CNA then removed the dangling call light cord and attached it to the upper right side of R3's shirt, close to R3's shoulder. V30 CNA then directed R3 to push the call light button if R3 needs anything, and V30 would come back to help R3. R3 stated "I can't see that thing. I don't see well at all. If I can't see it, I can't push it." V30 then clipped the call light button lower and centered on R3's chest. R3 pushed the call light immediately. V30 CNA then stated to R3 "That was good practice. Do that if you need me. I will move your wheelchair closer to your bed, but I don't want you to get up without calling us for help." 3. R2's current Diagnoses List documents the following: Diabetes Mellitus Type II, With Hyperglycemia, Diabetes Mellitus Type II, With Polyneuropathy (damage nerves, causing numbness, tingling, and weakness), Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Sites, Difficulty Walking, Not Elsewhere Classified. R2's Minimum Data Set (MDS) dated 3/4/26 documents R2's Brief Interview of Mental status (BIMS) score as 12 out of a possible 15, indicating moderate cognitive impairment. The same MDS documents R2 has had one fall with no injury (during the lookback period of this assessment) and is dependent on staff for substantial maximum assistance, with all Activities of Daily Living, except eating. R2's current Care Plan documents the following: "(R2) is at risk for falls r/t (related to) weakness, requires assistance with transfers, non. Ambulatory. "Encourage the resident to use the bell to call for assistance." R2's three progress notes below, each document recent unwitnessed falls without injury. R2's Fall/Incident Note (Unwitnessed) dated 3/24/26 at		S9999				

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S9999	Continued from page 11 10:20 am documents: R2 leaned over to pick up tennis shoes and fell out of R2's wheelchair. R2's Fall/Incident note dated 3/10/2026 at 8:31 pm documents: An unidentified Certified Nursing Assistant went in and found resident was lying on the floor on R2's back, against the wheelchair behind him, sitting in front of the toilet. R2's Fall/Incident note dated 3/6/2026 at 03:48 am documents: Resident was trying to reach for his bag and slipped off R2's bed. On 4/3/26 at 8:55 am, R2 was lying in an elevated bed. R2's bed was elevated with the mattress approximately three and a half feet off the floor. The head of R3's bed was positioned at approximately 45 degrees. R2's bed control device was behind the elevated head of the bed. R2's bed control device was attached to R2's headboard, behind the mattress, centered behind R2's head. R2 did not have R2's call light within reach. R2's call light cord was coiled on the floor under the head of R2's bed. R2 stated, "I have no way of asking staff for help when my call light is not up on my bed. I cannot reach the bed control for my bed, and I sure don't like my bed off the floor, this far. I woke up like this when the dietary people brought my food. I am thinking, this probably is how the night shift left me when they changed me in the middle of the night." On 4/3/26 at 9:03 am, a V40 Certified Nursing Assistant (CNA) entered R2's room and confirmed R2's bed was not at a safe height, the call light was on the floor, and R2's bed control was out of reach. V40 CNA lowered R2's bed to approximately two and a half feet off the floor and handed R2 the bed control and attached R2's call light to R2's clean bed linen within R2's reach. 4. R8's current Diagnoses List includes the following: "Essential (Primary) Hypertension, Repeated Falls, Difficulty Walking, Not Elsewhere Classified, Other Abnormalities of Gait and Mobility, Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Sites, Age-Related Osteoporosis Without Current Pathological Fracture, and Other Specified Disorders of Bone Density and Structure, Site Unspecified. R8's Minimum Data Set (MDS) dated 4/1/26 documents R8's Brief Interview of Mental Status (BIMS) score as 11 out of a possible 15, which indicates moderate cognitive impairment. The same MDS documents R8 has had two falls, without major injury, while residing in the facility.			S9999			

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S9999	Continued from page 12 R8's current Care Plan documents the following: "(R8) is at risk for falls, has Osteoporosis and Osteopenia, which could contribute to falls/ severity of illness. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance." R8's (most recent fall) Nursing Note dated 3/25/2026 at 10:22 pm, documents the following: "Note Text: 2030 (8:30 PM)- patient fell after standing up from recliner in room. CNA (Certified Nursing Assistant) entering room when patient fell. Right side of (R8's) head hit bedside table causing laceration. Large skin tear to right elbow. Bleeding controlled with pressure to both sites." On 4/3/26 at 8:10 am, R8 was seated in a wheelchair three feet from R8's bed. R8's call light cord was attached to R8's pillowcase on R8's bed. R8 stated, "I can't reach that call light (stretching his right arm out, falling short approximately 18 inches from the call light). I can't call those girls if I need something." On 4/3/26 at 8:15 am, a V37 Certified Occupational Therapy Assistant (COTA) confirmed R8's call light was out of R8's reach. V37 COTA stated to R8, "Let me fix that. You should always have your call light within reach. I am sorry about that." 5. R9's current Diagnoses List documents the following: "Repeated Falls, Encephalopathy, Unspecified, Cerebral Aneurysm, Non-ruptured, Muscle Wasting and Atrophy Not Elsewhere Classified, Multiple Sites, Difficulty Walking, Not Elsewhere Classified, Other Abnormalities of Gait and Mobility, Other Lack of Coordination, and Cognitive Communication Deficit. R9's current Physician Order Sheet documents the following: "LAL (Low Air Loss) mattress- Dial must be set at resident's weight. Loose sheet only or bed pad only under resident to not disturb pressure relieving device." R9's Minimum Data Set (MDS) dated 2/12/26 documents R9's Brief Interview of Mental Status (BIMS) score as nine out of a possible 15 indicating moderate cognitive impairment and has a pressure reducing device for the bed. R9's Fall risk assessment dated 02/02/26 documents R9 is at high risk for falls.		S9999				

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S9999	Continued from page 13 On 4/07/26 at 8:45 am, a V48 Certified Occupational Therapy Assistant (COTA) came out of resident R9's bedroom. V7 Licensed Practical Nurse (LPN) was standing at V7's medication cart in the hallway outside R9's room. V48 COTA told V47 LPN that R9's low-air-loss mattress had deflated. V48 stated that V48 found it almost flat while R9 was lying in the bed. On 4/07/26 at 8:48 am, V48 COTA re- entered R9's bedroom with this surveyor. R9 laid in bed, on V48's left side, asleep. V48 COTA stated V48 had found R9's air mattress had deflated "again" this morning. V48 COTA stated V48 did not initially know why. "I let (V49 Certified Nursing Assistant/CNA) know it was deflated. (V49 CNA) came in and found the plug (beach-ball-like) had come out. (R9's) bed (low air loss mattress) had deflated maybe, halfway flat. I completed a stopwatch (maintenance request form) report, so it will be fixed. I know it happened this weekend too. It needs to be fixed." V48 then lifted an orange piece of material that flapped over the air mattress plug. The plug was off, and the air mattress was losing air. V48 stated "It is not functioning right. It (beach ball type plug) has popped out, again." V48 used force to push the air mattress plug back in. On 4/07/26 at 9:20 am, V49, a Certified Nursing Assistant (CNA), explained that when V49 identified the problem with R9's low air loss mattress not holding air. V49 stated "The night Supervisor V32 Registered Nurse / Supervisor) showed me one evening, when I worked over (past her day shift schedule), about a week ago. (R9's) The air mattress had gone flat. I was going to get her (R9) up from the bed. She (R9) has had pressure ulcers previously, and that is why she (R9) is supposed to be on a low-air-loss mattress. (V32 RN Supervisor) showed me (V49) why it went flat. The plug had popped open. We did not have to get her (R9) out of bed. We stayed with her (R9) until it (air mattress) was filled back up." The facility policy "FALL MANAGEMENT PROGRAM" dated as revised January 2026 documents the following: "POLICY - To provide guidelines on preventing resident falls or injury." "PROCEDURE: Complete the fall assessment initially on admission, and then quarterly." "Initial Plan of Care: 1. Initiate risk reducing interventions. 2. Verify and obtain orders if needed. 3. Develop an admission fall care plan."		S9999				

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S9999	Continued from page 14 "Action Steps: 1. Provide ongoing risk-reducing interventions. 2. Initiate physician orders as needed. 3. Identify and implement related care link interventions. 4. Provide ongoing evaluation of resident response to intervention (A)		S9999				