

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Allure of Mendota		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 First Avenue Mendota, IL 61342	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39537 Based on observation, interview, and record review the facility failed perform assessments, failed to continue to monitor a resident's change of condition, failed to communicate changes in a resident's condition, and failed to provide treatment of a fracture in a timely manner for 1 of 3 residents (R1) reviewed for quality of care in the sample of 7. These failures resulted in experiencing continued pain after a fall on 8/23/24 and a delay in her being sent to the hospital for evaluation and treatment. R1 was transferred to the hospital on 9/5/24 (2 weeks after she fell) and had surgery for a right hip fracture. The findings include: On 11/6/24 at 10:44 AM, R1 was lying in bed. R1 said there were two CNAs (Certified Nursing Aides) putting her back to bed, after lunch (on 8/23/24). R1 said the wheelchair was parked, facing the bed, near the middle of the bed. R1 said the CNAs applied the sling under her arm, she held onto the grab bar, and they used the lift to stand her up. R1 stated, I don't know what the problem was, but they were taking too long, and I told them I couldn't stand anymore. They pushed the lift over near the bed, but my legs weren't against the bed. They were trying to take of my pants, so I could lay down. It was taking too long, and I told them. Then my legs just gave out. I was hanging there, by my arms. The sling was pulling under my armpits and shoulder, and I was hanging on to the handles. They tried to sit me on the edge of the bed, but I was slipping. I landed on my butt on the floor. My right arm was sore right away and later on my right hip stated to really hurt. R1 said a nurse did not complete a head to toe assessment after she fell . R1 said the CNAs used the total lift to get her back in bed without the nurse checking her first. R1 said the facility did X-rays a couple days after she fell , but they told her there wasn't a fracture. R1 said she was having hip pain for two weeks before she was sent to the hospital. R1 said she had to have her hip repaired surgically. R1 said she wasn't able to do her regular therapy because her right hip was hurting too bad. R1 said she tried the sit to stand one more time, but it hurt so bad, and they had to stop. R1 said after that, she only did therapy in her bed, and it hurt when she did the leg exercises. R1 stated, I think someone made a mistake. I don't like to think about the fall. It was such an awful experience. I was just hanging from that sit to stand lift, by my arms for a long time and then I fell on my butt. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R1's Facesheet dated 11/6/24 showed diagnoses to include, but not limited to: right hip fracture and orthopedic aftercare (9/9/24); CHF (Congestive Heart Failure); COPD (Chronic Obstructive Pulmonary Disease); peripheral venous insufficiency; stroke with right sided weakness; major depressive disorder; morbid obesity; lymphedema; GERD (Gastro-Esophageal Reflux Disease); chronic pain syndrome; pain in right shoulder and right hip (9/9/24); reduced mobility; unsteadiness on feet; generalized muscle weakness; lack of coordination; and need for assistance with personal care. R1's facility assessment dated [DATE] showed she was cognitively intact; and was dependent on staff for toileting, shower/bathing, and transfers. R1's Progress Notes and Assessments were reviewed for 8/23/24. There were no notes or assessments (vital signs, neuro checks, ROM, pain, skin check) completed by R1's nurse (V18 - Agency RN). There were late entries created on 8/30/24 by V2 (DON - Director of Nursing) and V30 (MDS Coordinator). R1's Post Fall Evaluation dated 8/23/24 showed R1 had a witnessed fall in her room when she was being transferred to bed with a sit to stand mechanical lift, by V19 and V20 (CNAs). R1's Progress Note dated 8/25/24 showed, Resident complained of pain with ROM (Range of Motion) to right shoulder, right hip, and right lower extremity . The doctor was notified and orders for X-rays were obtained. (This note was 2 days after R1's fall). R1's portable Right hip X-ray report 8/25/24 showed there was no fracture or dislocation seen and she had moderate degenerative changes. R1's Health Status Note dated 9/5/24 showed R1 continued to complain of right hip pain after a fall on 8/23/24. The doctor was notified, and orders were received to send R1 to the hospital. R1's progress notes do not show continued assessments of R1 after her fall. R1's notes do not reflect that she was unable to bear weight in therapy, could no longer use the sit to stand lift, had pain with ROM/exercises with right leg, and was complaining of right hip pain from 8/25/24 until 9/5/24 (when she was sent to the hospital for continued right hip pain after a fall on 8/23/24.) R1's August and September 2024 MARs showed R1 took Norco (opioid pain medication) 5-325 mg 1 tablet 2-4 times a day for pain rated 3-9 on a 1-10 scale. R1's Occupation Therapy Notes dated 8/23/24 (before she fell) showed R1 was currently using the sit to stand machine for lifts and was completing tasks to increase her upper arm strength. On 8/26/24 R1's notes showed the therapist discussed attempting to get R1 up with a sit to stand lift tomorrow and R1 said she would try and wanted to work towards using the sit to stand again. R1's note on 8/27/24 showed she was a total lift transfer. R1's Physical Therapy Discharge Summary dated 5/20/24 to 9/6/24 showed R1's prior equipment was a sit to stand lift and wheelchair. This summary showed R1 was discharged to the hospital. This note showed, . Progress & Response to Treatment: The patient had been demonstrating good stability on the sit to stand lift for functional transfers but had fallen off the lift when transferring with the CNAs in her room. Patient had been complaining of RLE (right lower extremity) pain, was admitted to the hospital . (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/7/24 at 11:03 AM, V26 (RN - Registered Nurse) said she was familiar with R1 and verified that she had worked R1's hallway between 8/23/24 (R1's fall) and 9/5/24 (R1's transfer to hospital - 2 weeks later). V26 said R1 was alert and oriented. V26 said R1 had chronic issues of pain and had complained of hip pain occasionally. V26 said she gave R1 Norco and tried to stay on top of her pain. V26 said she was not aware that R1 was not able to bear weight in therapy and was having right hip pain with movement of her right leg. V26 stated, They don't always tell us stuff. If I knew R1 fell and she was having those problems, I'd assume her hip was broken and call the doctor to send her to the hospital as soon as possible. But no one told me that. On 11/7/24 at 8:54 AM, V22 (RN) said she was working 9/5/24 (when R1 was sent to the hospital). V22 said she was not assigned to R1 but was the supervisor working that day. V22 said V25 (R1's nurse) came to her because she didn't know what to do. V22 said V25 reported R1 had a fall on 8/23/24 and was complaining of right hip pain rated at a 10 on a 1-10 scale. V22 said she told her to call the nurse and helped call 911. V22 said that's why she entered a note on 9/5/24. V22 said if a resident had a fall and is complaining of severe hip pain, they need to be sent out as soon as possible because there may be a fracture. On 11/7/24 at 1:02 PM, V2 (DON) said she was at the facility on 8/23/24. V2 said she didn't witness R1's fall, was not in R1's room after the fall and didn't not complete an assessment on R1 on 8/23/24. V2 said the CNAs did not report a fall. V2 said she was in the hall and overheard V19 talking. V2 said V19 reported a rough transfer, but not a fall. V2 said she didn't ask any other questions and went to deal with another issue. V2 said on 8/25/24 she got a call from V1 (Administrator). V2 said she was told R1 was having pain all over, and was asked if there had been an incident. V2 stated, I told her that I heard there was a rough transfer but wasn't aware of an incident. She (V1) said [R1] did go on the floor and that's considered a fall. They got orders for X-rays. I didn't come in that day or do an assessment. The nurses should be documenting a fall and their assessment in the progress notes. The purpose is to ensure there is continuity of care and communicate with other staff what has been happening with the resident. On 8/30/24 we had a fall meeting and were reviewed R1's documentation and realized there was no charting on 8/23/24 about the fall. V2 said, If a resident is complaining of pain with ROM after falling, then the resident shouldn't be moved and sent out 911 to the hospital. I don't have X-ray vision. I can't tell if there is a fracture by looking at them. The nurses should have charted all of that information, but the CNAs didn't report a fall. V2 said the nurses should have performed and documented continued assessments of R1 after she fell to ensure there wasn't an injury. V2 said she was not aware that R1 was having pain with movement of the right leg and was no longer able to bear weight. V2 said therapy did not report that to her. V2 said if she had known, then she would have sent R1 out to the hospital sooner for further evaluation. V2 said R1's progress notes and assessments should reflect a timeline of R1's injuries and complaints. V2 said R1's progress notes did not contain the pertinent nursing assessments to demonstrate a thorough assessment. V2 said the purpose of continued assessments, documentation of findings, and interdisciplinary communication of resident's change of condition is to ensure the resident is receiving proper care and continuity of care can be maintained. (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/7/24 at 11:26 PM, V27 (NP - Nurse Practitioner) said she is familiar with R1 and took care of her before she was admitted to the facility. V27 said she would expect the staff to complete a head to toe assessment after a fall, continued assessments of the resident, and to document their assessments. V27 said the nurses will notify her or the physician of falls. V27 said if there is an injury then they call right away, but if not, injury they may send a message. V27 said she wasn't sure when she was notified of R1's fall. V27 said she doesn't document her phone communication with the facility. V27 stated, The facility is responsible for maintaining that documentation. V27 said she had not done an assessment on R1 between 8/23/24 - 9/5/24. V27 said she expects the staff to perform and assessment and notify her of any changes in the resident condition. V27 said she isn't an orthopedic doctor, but inability to bear weight, increased pain upon palpation of the right hip area, or increased pain with movement of the right leg could be indications of a fracture. V27 said she would expect the staff to notify her immediately with these symptoms, so the resident can be transferred to the hospital for further evaluation. V27 said it's possible that R1's fall on 8/23/24 contributed to her right hip fracture, but she was not an orthopedic doctor. On 11/7/24 at 3:08 PM, V28 (Orthopedic Surgeon) said it's very likely that the initial portable X-ray completed on 8/25/24 did not capture the fracture due to R1's body size and positioning with portable X-ray machines. V28 said an MRI would be needed for more sensitive results. V28 said inability to bear weight, pain in the hip area, or pain with ROM/movement of the affected limb are signs of a fracture. V28 said the facility should report these concerns to the physician and obtain an order to send the resident to the hospital for further evaluation. V28 said he wasn't clear how R1 fell . The surveyor explained the fall from the sit to stand lift. V28 replied, It's very likely that caused her fracture, and the original X-ray missed it. If she was complaining of continued pain and hadn't returned to baseline physical functioning, they should have sent her to the hospital. She ended up having surgery to repair her hip. The pain she was having was likely from the fracture and she needed stabilization (surgery) on her hip to reduce the pain. The facility's undated Safe Resident Handling/Transfers Policy showed, It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure, and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines . The facility's undated Fall Prevention Program showed, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Definitions: A fall is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force (e.g. resident pushes another resident). The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere . 9. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury. The facility's undated Fall Checklist showed, #1. Complete assessment/VS, initial neuro checks as indicated. If any injury noted or suspected keep resident still and do not transfer to bed or chair. Contact 911 and send to ED for evaluation and treat .		

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39537 Based on observation, interview, and record review the facility failed to safely perform a mechanical lift transfer and failed to follow their policy and procedure after a fall for 1 of 3 residents (R1) reviewed for safe transfers in the sample of 7. This failure resulted in R1 falling to the floor, sustaining a right hip fracture, and requiring surgical repair of the fracture. The findings include: On 11/6/24 at 10:44 AM, R1 was lying in bed. R1 said there were two CNAs (Certified Nursing Aides) putting her back to bed, after lunch (on 8/23/24). R1 said the wheelchair was parked, facing the bed, near the middle of the bed. R1 said the CNAs applied the sling under her arm, she held onto the grab bar, and they used the lift to stand her up. R1 stated, I don't know what the problem was, but they were taking too long, and I told them I couldn't stand anymore. They pushed the lift over near the bed, but my legs weren't against the bed. They were trying to take of my pants, so I could lay down. It was taking too long, and I told them. Then my legs just gave out. I was hanging there, by my arms. The sling was pulling under my armpits and shoulder, and I was hanging on to the handles. They tried to sit me on the edge of the bed, but I was slipping. I landed on my butt on the floor. My right arm was sore right away and later on my right hip stated to really hurt. R1 said a nurse did not complete a head to toe assessment after she fell . R1 said the CNAs used the total lift to get her back in bed without the nurse checking her first. R1 said the facility did X-rays a couple days after she fell , but they told her there wasn't a fracture. R1 said she was having hip pain for two weeks before she was sent to the hospital. R1 said she had to have her hip repaired surgically. R1 said she wasn't able to do her regular therapy because her right hip was hurting too bad. R1 said she tried the sit to stand one more time, but it hurt so bad, and they had to stop. R1 said after that, she only did therapy in her bed, and it hurt when she did the leg exercises. R1 stated, I think someone made a mistake. I don't like to think about the fall. It was such an awful experience. I was just hanging from that sit to stand lift, by my arms for a long time and then I fell on my butt. R1's Facesheet dated 11/6/24 showed diagnoses to include, but not limited to: right hip fracture and orthopedic aftercare (9/9/24); CHF (Congestive Heart Failure); COPD (Chronic Obstructive Pulmonary Disease); peripheral venous insufficiency; stroke with right sided weakness; major depressive disorder; morbid obesity; lymphedema; GERD (Gastro-Esophageal Reflux Disease); chronic pain syndrome; pain in right shoulder and right hip (9/9/24); reduced mobility; unsteadiness on feet; generalized muscle weakness; lack of coordination; and need for assistance with personal care. R1's facility assessment dated [DATE] showed she was cognitively intact; and was dependent on staff for toileting, shower/bathing, and transfers. R1's Progress Notes and Assessments were reviewed for 8/23/24. There were no notes or assessments (vital signs, neuro checks, ROM, pain, skin check) completed by R1's nurse (V18 - Agency RN). There were late entries created on 8/30/24 by V2 (DON - Director of Nursing) and V30 (MDS Coordinator). R1's Post Fall Evaluation dated 8/23/24 showed R1 had a witnessed fall in her room when she was being transferred to bed with a sit to stand mechanical lift, by V19 and V20 (CNAs). (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/6/24 at 3:46 PM, V19 (CNA) said she was the CNA helping V20 transfer R1 to bed on 8/23/24. V19 said they were transferring R1 from her wheelchair to bed and tried to change her incontinence brief before sitting her down on the edge of the bed. V19 said R1 said she couldn't hold herself up any longer, her legs went weak, and she collapsed. V19 said she placed her knee behind R1 to try to keep her from sliding off the bed. V19 said some of her bottom was on the bed, but not all of it. V19 said she told V20 to get help because she couldn't hold R1 for long, her knee was starting to hurt. V19 said V20 thought we could push R1 into the bed, but I told her that wouldn't work, and we needed help. V19 stated, [V20] left the room to go get help. I don't how long she was gone but felt like a long time. I told [R1] we were going to have to lower her to the floor because my knee was hurting. We lowered her to a seated position on the floor. One of her legs was in an awkward position. It was a little twisted. I don't remember which one. She seemed scared because we got scared. She was complaining of pain, but I don't remember exactly what she said. She was hanging from the lift for quite a while. All of it was so sudden. She said, I can't, my feet. By the time [V20 and V21 (CNAs)] came back in the room, I was already lowering R1 to the floor. [V20] and I got the total lift, and we got her back to bed. The nurse didn't come in and assess her before we got her back to bed. [V20] and we got write ups for this. I was surprised the nurse didn't come. [V20] said the nurse isn't coming because she's pregnant. I know we shouldn't have gotten her up until the nurse assessed her. On 11/7/24 at 8:38 AM, V21 (CNA) said she was providing care to another resident when V20 said they needed help in R1's room. V21 said when she went in the room, V19 had her knee underneath R1 and R1 was hanging from the sit to stand lift. V21 stated, There's no way [V19] could have held R1 for long. V21 said she and V20 help lower R1 to the floor. V21 said she left R1's room after that. V21 said when a resident falls the nurse should be notified right away. V21 said the nurse does an assessment and tells us if it's safe to transfer the resident. V21 said we don't want to hurt the resident if they have injuries already. On 11/7/24 at 12:01 PM, V18 (Agency RN) said she was R1's nurse on 8/23/24 but she had no idea R1 fell . V18 said the CNAs didn't tell her R1 fell . V18 said she was charting at the nurses' station, and she was approached by therapy. V18 said therapy reported that R1 had a rough transfer. V18 said she went to R1's room about 30 minutes later. V18 said the CNAs were in R1's room and she asked if there was an incident. They said it was a rough transfer. V18 said no one reported a fall to her, she didn't complete an assessment of R1 after the fall, and there wasn't any documentation because she wasn't aware R1 fell . V18 stated, If I knew about a fall, then I would have started the assessments and paperwork immediately. If you're going to have a fall, a witnessed fall is the easier one to have. It's less paperwork. All R1 said was she didn't want to use the sit to stand anymore, she stated, I don't want to do that again. Then I heard a few days later she told someone else she fell , and she was sent out to the hospital. V18 said she didn't take care of R1 again until she returned from the hospital after she had surgery on her broken hip. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Allure of Mendota		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 First Avenue Mendota, IL 61342	
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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/7/24 at 9:55 AM, V23 (PTA - Physical Therapy Assistant) said prior to R1 falling, they had been working training with the sit to stand. V23 said a sit to stand lift was performed in the therapy gym successfully and he had completed in room training with the CNAs on sit to stand transfers for R1. V23 said R1 was doing well with the training and could bear weight for several minutes during the transfer. V23 said he was surprised when he heard there was a rough transfer on 8/23/24 (Friday). V23 said he saw R1 the following Monday or Tuesday and attempted the sit to stand lift and R1 could not bear weight. V23 said R1 complained of right hip pain and demanded to stop. V23 said he didn't attempt the sit to stand lift with R1 again and after that her therapy consisted of exercises in the bed or wheelchair and the staff used a total lift for transfers. V23 said R1 often had pain with ROM and exercises with her right leg. On 11/7/24 at 12:42 PM, V30 (MDS Coordinator) said she did not witness R1's fall, nor did she assess R1 on 8/23/24. On 11/7/24 at 1:02 PM, V2 (DON) said she was at the facility on 8/23/24. V2 said she didn't witness R1's fall, was not in R1's room after the fall and didn't not complete an assessment on R1 on 8/23/24. V2 said the CNAs did not report a fall. V2 said she was in the hall and overheard V19 talking. V2 said V19 reported a rough transfer, but not a fall. V2 said she didn't ask any other questions and went to deal with another issue. V2 said on 8/25/24 she got a call from V1 (Administrator). V2 said she was told R1 was having pain all over, and was asked if there had been an incident. V2 stated, I told her that I heard there was a rough transfer but wasn't aware of an incident. She (V1) said [R1] did go on the floor and that's considered a fall. They got orders for X-rays. I didn't come in that day or do an assessment. The nurses should be documenting a fall and their assessment in the progress notes. The purpose is to ensure there is continuity of care and communicate with other staff what has been happening with the resident. On 8/30/24 we had a fall meeting and were reviewed R1's documentation and realized there was no charting on 8/23/24 about the fall. V2 said after a fall she expects the CNAs to report the fall immediately, the nurse to perform a full head to toe assessment of the resident and determine if it is safe to transfer the resident from the floor. If a resident is complaining of pain with ROM after falling, then the resident shouldn't be moved and sent out 911 to the hospital. I don't have X-ray vision. I can't tell if there is a fracture by looking at them. The nurses should have charted all of that information, but the CNAs didn't report a fall. On 11/7/24 at 3:08 PM, V28 (Orthopedic Surgeon) said it's very likely that the initial portable X-ray completed on 8/25/24 did not capture the fracture due to R1's body size and positioning with portable X-ray machines. V28 said an MRI would be needed for more sensitive results. V28 said inability to bear weight, pain in the hip area, or pain with ROM/movement of the affected limb are signs of a fracture. V28 said the facility should report these concerns to the physician and obtain an order to send the resident to the hospital for further evaluation. V28 said he wasn't clear how R1 fell. The surveyor explained the fall from the sit to stand lift. V28 replied, It's very likely that caused her fracture, and the original X-ray missed it. If she was complaining of continued pain and hadn't returned to baseline physical functioning, they should have sent her to the hospital. She ended up having surgery to repair her hip. The pain she was having was likely from the fracture and she needed stabilization (surgery) on her hip to reduce the pain. V19 and V20's Employee Disciplinary Forms dated 8/29/24 showed R1's fall was not reported to the nurse. They were provided education and in-servicing. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The facility's undated Safe Resident Handling/Transfers Policy showed, It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure, and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines . The facility's undated Fall Prevention Program showed, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Definitions: A fall is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force (e.g. resident pushes another resident). The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere . 9. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury. The facility's undated Fall Checklist showed, #1. Complete assessment/VS, initial neuro checks as indicated. If any injury noted or suspected keep resident still and do not transfer to bed or chair. Contact 911 and send to ED for evaluation and treat .		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on interview and record review the facility failed to provide sufficient staffing to meet resident's needs. This has the potential to affect all residents in the building. The findings include: The facility's resident roster dated 11/6/24 showed 67 residents reside in the facility. R1's face sheet dated 11/6/24 showed diagnoses including but not limited to right femur fracture, orthopedic after care, right side paralysis, morbid obesity, and history of falls. R1's facility assessment dated [DATE] showed no cognitive impairment and total staff assistance for transfers and toileting. The same assessment showed R1 is always incontinent of urine and bowel. R3's face sheet dated 11/7/24 showed diagnoses including but not limited to urinary tract infection, clostridium difficile, use of an ostomy bag (for collection of stool via the intestines), and muscle wasting. R3's facility assessment dated [DATE] showed no cognitive impairment and total staff assistance for transfers and toileting. The same assessment showed R1 is frequently incontinent of urine. R5's face sheet dated 11/7/24 showed diagnoses including but not limited to diabetic peripheral angiopathy, lumbar region disc degeneration, peripheral venous insufficiency, chronic kidney disease, osteoarthritis of knee, and muscle wasting. R5's facility assessment dated [DATE] showed moderate cognitive impairment and total staff assistance for transfers and toileting. The same assessment showed R5 is frequently incontinent of urine and bowel. R7's face sheet dated 11/7/24 showed diagnoses including but not limited to diverticulosis of intestine, obesity, gastric ulcer, osteoarthritis, malaise, and muscle weakness. R7s facility assessment dated [DATE] showed no cognitive impairment and total staff assistance for transfers and toileting. The same assessment showed R7 is frequently incontinent of urine and occasionally incontinent of bowel. On 11/6/24 at 10:44 AM, R1 was lying in her bed. R1 said sometimes she must wait over two hours for her call light to be answered. R1 said it's worse at night. R1 said if they don't come in time then we just have to go to the bathroom in our pants. R1 stated, It's so embarrassing. On 11/6/24 at 11:08 AM, R6 self-propelled her wheelchair down the hall, into her room. R6 said the staff that works at the facility is wonderful, but they need more help and more slings. R6 stated, I blame that on the owners. They should make sure there is enough people working and enough slings. The other night I was stuck in bed all day and night because they didn't have the help or a sling to get me up. I have to use a total lift. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/6/24 at 11:30 AM, R3 was lying on her bed and stated the aides take too long to answer my call light. R3 said, Sometimes it is over an hour. I have to wait so long I end up going to the bathroom in my pants. Sometimes I just transfer to the toilet alone. They (staff) frown on that but I can't wait any longer. It takes a long time to get help to change me too. It seems like there is a lot of staff calling off and not coming in to work. There isn't any one particular shift that is bad, they are all bad. There just isn't enough help. On 11/7/24 at 9:10 AM, R5 was lying in bed and stated she needs help to walk or get out of bed. R5 said, They (staff) make me wait around to get me up or lay me down. I just have to lay here and wait till someone shows up. Most of the time I have already wet or went number two in my pants. They take too long to get me out of bed and into the bathroom. On 11/6/24 at 2:35 PM, R7 was seated in an upright recliner and stated call light response time varies depending on what is going on in the building. R7 said it is frequently a long wait time and many times she goes to the bathroom in her pants. R7 said there are a lot of times more CNAs (Certified Nurse Aides) are needed so she isn't sitting and waiting so much. R7 said staff leave her on the toilet way too long and it gets annoying. R7 said the evening wait times are even longer. She can't get into bed when she wants to. R7 stated she uses a mechanical sit to stand to transfer. Aides do it with only one person a lot of the time because they can't find a second aide to help. R7 said only one aide is used at least 50% of the time. On 11/6/24 at 2:40 PM, V9 (CNA) and V10 (CNA) were interviewed together. V9 stated it is difficult to find coworkers to help with resident care at times. V9 said a few disappear when call lights go off. V9 said two CNAs are required for all mechanical lift transfers. On 11/7/24 8:38 AM, V21 (CNA) said she comes in at 5:00 AM for the day shift. V21 said there are days that are very hectic, and many residents are soiled (in urine or feces) when she comes in. V21 said she doesn't work nights, so she doesn't know what it's like. V21 said maybe there were call offs. On 11/7/24 at 9:50 AM, V13 (CNA) stated there is absolutely not enough staff for resident care. V13 said CNA staffing numbers were reduced by administration about three weeks ago, but it has been a problem since early spring. V13 stated some aides are forced to transfer residents without two people. The evening cares can't get done on time. Wet or soiled residents have to wait longer until they can be changed. V13 said the overnight rounds don't get done on time because there isn't enough staff. V13 said several other CNAs are having the same issues. Three other evening or night CNAs were attempted to be reached for interview. Calls were not returned before the end of the survey. On 11/7/24 at 11:00 AM, V2 (Director of Nurses) stated it is a facility expectation that call lights are answered in 3-5 minutes. V2 said, Staff should at least be addressing the resident and let them know they will be back if they are busy. It is a safety thing. They can't know if it is an emergency if they don't go check on the resident. It is unsafe to be transferring residents without two staff and unsafe for residents to do it by themselves. It is embarrassing for residents to have to go to the bathroom in their briefs. It makes them feel horrible, like anyone would feel. V2 stated long call light response times could be an indication more staff are needed. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility was unable to provide any policy related to staffing. The facility's Resident Rights policy last review dated 7/1/24 stated under the respect and dignity section: c. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences, except when to do so would endanger the health or safety of the resident or other residents. The policy stated under the self-determination section: b. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.		