STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145422	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Havens Senior Living	1790 South Fairview Avenue Decatur, IL 62521

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interviews, and record review, the facility failed to ensure a resident's right to dignified care by failing to provide timely incontinence care. This failure affected one of three residents (R7) reviewed for dignity/incontinence care on the sample list of 14. Findings include: R7's Diagnoses list dated 11/07/24 documents the following: Gullian' Barre Syndrome (serious autoimmune disorder that aggressively attacks all nerve cells within the peripheral nervous system, that leads to partial or complete paralysis), Muscle Weakness, Morbid (Severe) Obesity, and Unspecified Abnormalities of Gait and Mobility. R7's Minimum Data Set (MDS) dated [DATE] documents R7's Brief Interview of Mental status score as 15 out of a possible 15, indicating no cognitive impairment. The same MDS documents R7 is frequently incontinent of bladder and always incontinent of bowel. R7's same MDS documents: Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. 01. (marked as number one) Dependent - Helper does ALL of the effort. Resident does 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 11:40 am R7 stated The Call lights, I can cut them a little slack. I know they are busy. I was upset last week. I put on my call light after breakfast, and it was answered within 15 minutes. I had a bowel movement. I told the CNA (unidentified, Certified Nursing Assistant). She said she would be right back. I know they have to get the (name brand full-body mechanical lift) and extra people to transfer me. Therapy (unidentified staff) came in about 11:00 am. I had been waiting a good hour to an hour and a half by then. I told therapy I was waiting for staff to change me, so I couldn't do therapy yet. I had put my call light on again. No one answered it. Therapy returned about 25 minutes later. (V17, Physical Therapy) and (V18, Occupational Therapist) changed (provided incontinence care) me, so I could do my therapy. I have never been more humiliated in my life. I had (expletive for bowel excretions) everywhere. That same day, I put on my call light about 3:30 pm. The evening CNA (unidentified) did the same thing. She said she would be back. I had another bowel movement and had to lay in it until after supper. Dietary staff brought me my supper tray. That girl (unidentified dietary staff) said she would tell my CNA that I needed changed. I couldn't eat very much. I lost my appetite. I did not get changed until close to 8:00 pm. My skin gets irritated easily. Laying in (expletive for bowel excretions) makes it breakdown. On 11/20/24 at 11:50 pm V17, Physical Therapist confirmed V17 and V18 Occupational Therapist attempted to provide R7's therapy one day last week, and found R7 incontinent of bowel and bladder. V17 also stated Her (R7's) CNA (unidentified) did not respond to (R7) request to be changed. We (V17 and V18, Occupational Therapist) came back and the CNA had still not changed (R7). We changed her (R7) and completed our therapy evaluation. She was quite embarrassed. I reported this delay to the nurse (unidentified) I documented the event in my assessment note. R7's Physical Therapy Treatment Encounter Note dated 11/13/24 (time not specified), signed by V17, documents R7 is dependent on staff for mobility and all activities of daily living. The same note documents Noted (R7's) complaint about waiting for CNA (unidentified) for (name brand incontinent brief) and toileting hygiene but clinician (V17, Physical Therapist) and (V18) Occupational Therapist completed the activity at this time. On 11/20/24 at 12:30 pm V1, Administrator stated (R7) is very special to me. That is Definitely a dignity issue. No one (resident) should have to wait that amount of time to be changed. This will be fixed today. Staff need so more education. The facility RESIDENTS ' RIGHTS for People in Long-Term Care Facilities pamphlet dated as revised November 2018, documents the following: Rights to dignity and respect You have a right to make your own choices. Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis, condition, or payment source.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview, and record review, the facility failed ensure a resident's right to a clean, safe, comfortable homelike bathroom. This failure affects one of nine residents (R8) reviewed for resident rights/environment on the sample list of 14. Findings include: R8's Minimum Data Set, dated dated dated [DATE] documents R8's Brief Interview of Mental Status score as 13, out of a possible 15, indicated no cognitive impairment. On 11/22/24 at 12:25 pm R8's stated I don't see bugs or anything like that. The housekeepers do a good job cleaning my room. The bathroom is a problem. I have to hold my breath every time I go in there. It is bad, check it out. It is filthy. The housekeepers don't go in there either. You know its bad if they can't stand the smell. There is not a garbage can in there or it would probably be worse. I wear a (incontinence brief) in the case I don't make it and leak. Those (soiled incontinence brief) would end up in the garbage, and increase the bad odors. On 11/22/24 at 12:30 pm V23, Licensed Practical Nurse (LPN) entered R8's bedroom, and was approximately three feet from R8's bathroom door. V23, LPN stated I can smell it (bathroom foul odors) already. V23, LPN then entered R8's bathroom and confirmed the following: R8's bathroom had a strong-foul odor of feces and urine that permeated the room. R8's bathroom had a short, six inch long call light pull cord, with the call light outlet box on the wall behind the toilet. The call light outlet box was approximately two feet away from the toilet, and approximately head height of a person in a seated position. There was no exhaust ventilation fan running, and no fan activation switch. There was no suction of the solo exhaust vent on the bathroom ceiling. R8's toilet had a build-up of feces-like debris in and around the toilet bowl and around the rim of the toilet. R8's bathroom wall, around the toilet had visible, dried brown debris of feces-like splatters and yellow-brown urine-like splatters. R8's bathroom had a solo fluorescent light fixture that had a dim and blinking fluorescent light bulb resulting in poor lighting. The sink in R8's bathroom was pulled away from wall approximately two inches, and had loose chunks of a caulking-like substance in the space. V23, LPN stated This (R8's) bathroom really needs maintenance and housekeeping attention. The facility RESIDENTS' RIGHTS for People in Long-Term Care Facilities pamphlet dated as revised, November 2018 documents the following: Your facility must be safe, clean, comfortable and homelike.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on record review and interview, the facility failed to report an injury of unknown origin in a timely manner, to the State Agency. This failure affects one of three residents (R1) reviewed for bruises/injury of unknown origin on the sample list of 14. Findings include: The facility Long-Term Care Facility and IID-Serious Injury Incident Report form to Illinois Department of Public Health dated 11/22/24 (five days after the identification of R1's bruise documented below) documents R1's Initial report of R1 had a Serious Injury of Unknown Origin incident (type/bruise not identified) with a date of occurrence as 11/17/24 at 2:32 pm. R1's Minimum Data Set, dated dated dated [DATE] documents R1's Brief Interview of Mental Status score as four, out of a possible 15, indicating severe cognitive impairment therefore was not interviewable. R1's Nursing Note dated 11/17/2024 at 1:55 pm, signed by V10, Registered Nurse (RN)documents the following: Late Entry (bruise-11/17/24): Note Text: Res. (Resident) noted to use restroom and sit uncomfortably on toilet, per aide (V9, Certified Nursing Assistant) caring for res; writer assessed res. and noted raised blood blister. Discoloration slightly pink with dark center. (approximately). 1x1 in (one inch long by one inch wide) size. Loose skin noted to inner thighs, area appears to have been between res. and toilet during transfer. Continuing to monitor at this time. POA/MD (V28, Power of Attorney/ unidentified Physician) notified. R1's Nursing Note dated 11/18/2024 at 11:56 am, signed by V10, RN documents the following: Note Text: Writer assessed inner thigh (right) and noted area no longer raised and is flush to skin. Bruising/discoloration noted to be reddish purple in color and approx. (approximately) 2x3in. (two inches long by three inches wide). Has no c/o (complaint/of) pain with touch. Continuing to monitor at this time. On 11/19/24 at 3:25 pm V9, Certified Nursing Assistant (CNA) stated V9, CNA reported a bruise two days ago (11/17/24) on R1's right, upper, inner thigh. R1 had jerked when V9 sat R1 down on the toilet. V9 stated R1's had a bruised spot was on the back part of her inner upper leg, just below her private parts. V9 CNA also stated she reported R1's bruise right away to V10, RN who reported R1's bruise to V1, Abuse Prevention Coordinator/Administrator. On 11/22/24 at 12:45 pm V10, Registered Nurse (RN) stated the following: V10 RN was R1's nurse when R1's bruise on R1's upper inner thigh was identified. V10 stated V10 reported it to V1, Administrator/Abuse Prevention Coordinator, because V10 did not know what happened. V10, RN stated I reported it as an injury of unknown origin. The bruise was high up on (R1's) back inner thigh, close to her (R1's) who-hah. Because of the location of the bruise, I thought it would be considered suspicious, so I reported to (V1, Abuse Prevention Coordinator). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 2:00 pm V1 Administrator/Abuse Prevention Coordinator/Registered Nurse, confirmed she was informed of R1's bruise of unknown origin on 11/17/24. V1 stated V1 should have reported R1's right upper, inner thigh bruise, as an injury of unknown origin to Illinois Department of Public Health, immediately. On 11/22/24 at 2:05 pm V1, Administrator / Abuse Prevention Coordinator stated Even after talking about it (R1's bruise) Wednesday (documented above,11/20/24), I still haven't reported (R1's) bruise of unknown origin (identified 11/17/24) to IDPH. I will do that now (see late report above). The facility policy Abuse Prevention Program dated October 2022 includes staff direction as follows: VII. Internal Investigation Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately, but not more than two hours of the allegation of abuse, Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. 3. For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further, facts to make a determination as to whether the injury should be classified as an injury of unknown source. An injury should be classified as an injury of unknown source when both of the following conditions are met: 1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and 2. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview, and record review, the facility failed to thoroughly investigate an injury of unknown origin for one of three residents (R1), reviewed for injury of unknown/bruises on the sample list 14. Findings include: R1's Minimum Data Set, dated dated dated [DATE] documents R1's Brief Interview of Mental Status score as four, out of a possible 15, indicating severe cognitive impairment, and therefore was not interviewable. R1's Nursing Note dated 11/17/2024 at 1:55 pm, signed by V10, Registered Nurse (RN)documents the following: Late Entry (bruise-11/17/24): Note Text: Res. (Resident) noted to use restroom and sit uncomfortably on toilet, per aide (V9, Certified Nursing Assistant) caring for res; writer assessed res. and noted raised blood blister. Discoloration slightly pink with dark center approx. 1x1 in (one inch long by one inch wide) size. Loose skin noted to inner thighs, area appears to have been between res. and toilet during transfer. Continuing to monitor at this time. POA/MD (V28, Power of Attorney/ unidentified Physician) notified. R1's Nursing Note dated 11/18/2024 at 11:56 am, signed by V10, RN documents the following: Note Text: Writer assessed inner thigh (right) and noted area no longer raised and is flush to skin. Bruising/discoloration noted to be reddish purple in color and approx. (approximately) 2x3in. (two inches long by three inches wide). Has no c/o (complaint/of) pain with touch. Continuing to monitor at this time. R1's Skin and Wound Evaluation dated 11/19/24 (two days after right, upper, inner thigh bruise was identified 11/17/24) documents: 1. Area, 9.8 cm 2. Length, 2.8 cm 3. Width, 4.4 cm 4. Depth, not applicable R1's same Skin and Wound Evaluation fails to document the onset, location and type skin impairment. The same evaluation does not document that a full-body skin assessment was completed as directed by the facility Abuse Prevention Program policy documented below as part of a thorough investigation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 3:25 pm V9, Certified Nursing Assistant (CNA) stated I reported a bruise two days ago (11/17/24) on (R1's) right, upper, inner thigh. I don't know if it was there prior, but I know it hurt her when she sat down on the toilet. She (R1) jerked when I sat her down on the toilet. I could tell it hurt her to sit. I stood her up and repositioned her on the toilet. Her toilet seat does have bars. I did not bump the bars when I sat her down. The bruised spot was on the back part of her inner upper leg, just below her private parts. It looked like it may have been pinched. It was a dime size, dark red mark. I was careful and set her back down, taking extra caution. I reported to (V10, Registered Nurse). (V10, RN) came in and assessed the red area. Later in my shift the spot had gotten bigger and was dark purple. It had fluid in it. It was about nickel in size or a little more. I got the nurse again. When (V10, RN) looked at it again, She (V10) pushed around it (the bruised skin), (R1) flinched. She had pain around it when (V10) touched it. I have no idea how she got the bruise. I don't know if it was there before I sat her down. I did not see any skin tucked under the toilet seat, but I heard that was what they think happened. I did not see (V10) or anyone check the seat. So, I am not sure how that was determined. I did not see any way it could get caught. I don't know how it happened. I reported right away as we do with all new skin issues. (V10, RN) reported to the Administrator, as we do with all unexplained bruises. On 11/20/24 at 8:15 am V8, Licensed Practical Nurse (LPN)/Wound Nurse stated (R1) has a bruise on her right, upper inner thigh, acquired in the facility, that would be considered an injury of unknown origin because of the location, size and we don't really know what happened. I did not assess it until yesterday (occurred 11/17/24). I did not do a full skin assessment, so I don't know if she has any other bruises, I guess really, I should have. (V1, Administrator/Abuse Prevention Coordinator/Registered Nurse) was notified when it happened. She (V1) said it happened when (R1's) loose skin got caught under the toilet seat. I did not check the toilet seat, I assumed (V1) did, since she (V1) would be the one investigating (R1's) injury of unknown origin. I put an order in yesterday (two days after R1's bruise was identified) to monitor it every day. The care plan is now updated. On 11/20/24 at 1:00 pm V16, Restorative Aide and V11, Certified Nursing Assistant assisted R1 to the bathroom via wheelchair. While R1 was standing during transfer to the toilet, R1 had a dark purple and red bruise on R1's posterior aspect, of the right upper, inner thigh. R1's bruise measured approximately the size of a silver dollar coin. R1 stated Oh, that thing back there hurts. I don't know what happen. I just know it is tender. The bruise does not line up with the toilet seat opening. The toilet seat is secured and does not move. The toilet seat has bilateral grab bars that are anchored firmly to the toilet base. There is an approximate two-inch overhang of the toilet seat, between R1's thighs. The toilet seat space between R1's upper legs,does not line up with the base of the toilet. R1 has minimal upper inner leg skin that lays flat on the seat of the toilet. R1's has no excessive skin to reach the two inches under the seat to the base of the toilet. V11, CNA and V16, both stated they do not believe the bruise was caused by the toilet seat because it does not line up with the R1's bruise. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 1:19 pm V4, Hospice CNA stated It (R1's bruise) had to occur between last Thursday (11/14/24) and when I saw the bruise Monday (11/18/24). It had to have happened between my (Hospice care) visits. I check her (R1) skin every day I come. (R1's) bruise was really big. I would not have missed it. It was about four inches across and dark purple. V4 Hospice CNA also stated I do not believe (R1's) could have caught her thigh skin between the seat and the toilet rim. Myself and her (R1's Family Member V28) both agreed it looked more like (R1) was pinched by someone. Maybe overnight when she gets changed in bed. We were pretty sure it was not from the toilet seat like the facility said it was. V4, Hospice CNA went in (R1's) bathroom and showed (R1's) toilet seat overlaps the toilet by approximately two inches V4 stated It (toilet seat) does not make contact with the toilet where (R1's) bruise is. It could not have caused her (R1's) bruise. (R1) does not have enough excessive skin to reach under the toilet seat two inches, and get pinched. No one asked me anything about (R1's) bruise, or I would have showed them the toilet. I would have told them, I think that it (toilet) likely, did not cause the bruise on her thigh. It did not line up. On 11/22/24 at 12:45 pm V10, Registered Nurse (RN) stated the following: I was (R1's) nurse when the bruise on her thigh was identified. A Hospice nurse (V3) and (V9) CNA (Certified Nursing Assistant) told me (R1) got a bruise during transfer to the toilet. I looked at it. It looked more like a blood blister. (V9, CNA) told me again later it was spreading, and I looked at it again. It was flat then and had gotten a lot bigger. I reported it to (V1, Administrator/Abuse Prevention Coordinator), because I did not know what happened. I reported it as an injury of unknown origin. The bruise was high up on the back inner thigh, close to her (R1's) 'who-hah'. Because of the location of the bruise, I thought it would be considered suspicious, so I reported to (V1, Abuse Prevention Coordinator/Administrator). That is what we do when there is anything that could be abuse. It may have been from friction from the toilet seat. She has some loose skin on her upper inner thighs, that may have rubbed the toilet seat. She (R1) does not have a lot of loose skin there. It could have gotten caught as she moved back on the seat. I think it was likely that her skin got rubbed or pinched together onto itself, like folded together. I did not check the toilet seat for cracks or check to see how (R1's) bruise lined up with the toilet seat. I did not do a full body check to see if she had any other bruises or skin issues. The CNA's usually say something if there is anything new. On 11/20/24 at 2:00 pm V1 Administrator/Abuse Prevention Coordinator/Registered Nurse and V8, Wound Nurse/Licensed Practical Nurse (LPN) were interviewed together. V1 and V8, Wound Nurse/LPN both stated they did not assess the toilet seat or the environment to determine what caused R1 bruised right posterior, upper, inner thigh. V8 reiterated V8 did not complete a full skin assess to determine if R1 had any other bruises. V1 stated, I asked questions when (V10, Registered Nurse) called me to the report the bruise. I asked if the toilet could have pinched (R1). (V10, RN) said that it is possibly what happened. I did not interview anybody like I should have. V1 also stated I should have reported this as an IUO to IDPH immediately. I should have done a thorough investigation myself. I am a nurse. I did not even look at it. It falls on me. I should have looked at everything instead of taking (V10, RN) word for it. I should have gotten some interviews to complete a thorough investigation. The facility policy Abuse Prevention Program dated October 2022 includes staff direction as follows: POLICY (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. Internal Reporting Requirements and Identification of Allegations Supervisors shall immediately inform the administrator or person designated to act in the administrator's absence of all reports of incidents, allegations or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property. Upon learning of the report, the administrator or a designee shall initiate an incident investigation. VII. Internal Investigation Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health Immediately, but not more than two hours of the allegation of abuse, Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. 3. For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further, facts to make a determination as to whether the injury should be classified as an injury of unknown source. An injury should be classified as an injury of unknown source when both of the following conditions are met: * The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and * The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. If classified as an 'injury of unknown source, the person gathering facts will document the injury, the location and time it was observed, any treatment given and notification of the resident's physician, responsible party. The Department of Public Health will be notified. Time frames for reporting and investigating abuse will be followed. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. The same policy documents: (continued on next page)

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Fair Havens Senior Living	1790 South Fairview Avenue Decatur, IL 62521

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Investigation Procedures. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 31642 Based on interview and record review, the facility failed to provide a safe transfer with a mechanical stand lift. This failure affected one of three residents (R2) reviewed for injury of unknown origin/bruises on the sample list of 14. Findings include: R2's Diagnoses sheet last updated 11/14/24 documents the following: Cerebral Infarction, Unspecified, Other Disorders of Meninges, Not Otherwise Classified, Anxiety, Generalized, Repeated Falls, Difficulty Walking, Not Elsewhere Classified, Unsteadiness on Feet, Muscle Weakness Generalized, Other Lack of Coordination, and Need For Assistance With Personal Care. R2's Minimum Data Set (MDS) dated [DATE] documents R2's Brief Interview of Mental Status (BIMS) score of eight, out of a possible 15, which indicates moderate cognitive impairment. R2's same MDS documents the following: Safety and Quality of Performance - If helper assistance is required because resident ' s performance is unsafe or of poor quality, score according to amount of assistance provided. 01. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. R2's Toilet transfer: The ability to get on and off a toilet or commode is documented as 01. Dependent. R2's Care Plan last updated 11/14/24, documents the following: R2 has actual or risk for impairment. Bruise to right middle finger. Intervention: Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. R2's Nursing Note dated: 10/27/2024 at 3:54 pm signed by V27, Licensed Practical Nurse (LPN) documents the following: CNA (V13, Certified Nursing Assistant, previously employed by the facility) alerted nurse (V27, LPN) that resident (R2) was being toileted in the bathroom with a sit to stand lift and resident's middlem right finger got caught between the grab bar and sit to stand handle. Writer observed finger tip had bruised and began to swell. Resident (R2 was not avaible for interview, discharged from the facility. BIMS 8/15 as noted above) stated, 'It was an accident while I was going to the toilet. It doesn't hurt'. R2's Bruise/Discoloration (Risk Report) dated 10/27/24 at 3:30 pm documents the same incident above and included Predisposing Environmental Factors: Crowding. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Skin /Wound Note dated 10/28/24 at 9:35 am, signed by V8, Licensed Practical Nurse (LPN)/Wound nurse documents the following: Writer evaluated resident's (R2's) R (right) middle finger. Resident has a bruise on her finger. Bruise is dark purple in color. Measurements: 7.44cm (centimeters, long) x 4.77cm (wide) x 1.94cm (depth).Intervention: Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Resident aware and agreeable to intervention. PMD (Primary Medical Doctor, unidentified) updated. The facility Training Sign-in Sheet dated 10/28/24 documents Training Provided: Proper transfer - where to find transfer status, locking lifts, amount of people assisting etc (etcetera), making sure all extremities are in proper '(safe)' position before transferring, and during transfers. On 11/20/24 at 8:15 am V8, LPN/Wound Nurse stated (R2) smashed her finger between the bar on the toilet, and the sit to stand lift. V8 also stated There is not a lot of room in the bathroom. Staff were educated on safe transfers. V8 also stated I think sometimes they (staff transferring residents) get rushed and don't pay close attention. They should always be watching the residents close when using the lifts. I think (V27, LPN) was her (R2) nurse. On 11/22/24 at 1:00 PM V27, LPN stated I was in another residents (unidentified) room when CNA (V13 Certified Nursing Assistant previously employed by the facility) came and said (R2's) finger got caught between the handle of the sit to stand (lift) and the toilet grab bar, because there was not enough room in the bathroom to maneuver the lift. I went in right away and checked her (R2) finger. The top of her (R2's) finger was already swelled up like a balloon. It was black and dark purple. She (R2) said it did not really hurt. It looked painful though. (R2) said it was just an accident. On 11/19/24 at 10:20 am V1 Administrator/Abuse Prevention Coordinator/Registered Nurse stated R2' injured her finger during a transfer with at mechanical stand lift, while toileting. V1 stated the CNA should have made sure R2's hands were placed properly during transfer.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 31642 Based on observation, interview and record review the facility failed to employ a full-time Director of Nursing. This failure affects all 109 residents residing in the facility. Findings include: On 11/19/24 at 9:15 am, V1, Administrator stated the facility has not had a full-time Director of Nursing in six months. Throughout the survey, 11/19/24 - 11/22/24, there was no Director of Nursing (DON) working in the facility. The facility CMS-802 Matrix form dated 11/19/24 documents 109 residents reside in the facility.