STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145607	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Palos Heights	7850 West College Drive Palos Heights, IL 60463

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on observations, interviews, and record reviews, the facility failed to follow their policy and procedures for proper nursing care by not ensuring a resident who requires assistance with transfers was immediately assessed for injury after being found in an abnormal position and not ensuring the incident was immediately documented in the residents medical record and the physician and family were notified. This failure applies to one of three residents (R1) reviewed for quality of care. Findings include: R1 is an [AGE] year-old male with a diagnoses history of Parkinson's Disease, Dementia, Major Depressive Disorder, Muscle Wasting and Atrophy, Psychotic Disorder with Delusions, Diverticulitis, Cardiomegaly, Atherosclerotic Heart Disease, Encephalopathy, Malignant Neoplasm of Spinal Cord, and chronic kidney disease who was admitted to the facility 01/27/2020. On 10/02/2024 at 11:21 AM Observed R1 sitting in a wheelchair in the dining room. Observed R1 wearing a sling on his right arm, observed R1's right arm covered in bruises and observed bruises on R1's left arm. R1's progress note created by V12 (Licensed Practical Nurse) dated 9/22/2024 at 12:30 PM documents he was noted with bruising and swelling to his right upper arm, he is unable to move extremity without pain. Abuse Coordinator notified; note created by V13 (Registered Nurse) at 1:30 PM documents writer was notified that resident has a new bruise and swelling to right upper arm; Resident noted guarding right arm, not allowing writer to assess for range of motion. Called and spoke with V27 (Physician) with new orders to send resident to the ER for evaluation. R1's progress note created on 9/22/2024 21:27:28 by V11 (Agency Licensed Practical Nurse) documents note is a late entry for 9/21/2024 21:30; and states during rounds noted resident with legs hanging over the footboard of his bed, entered the room to observe and called CNA (Certified Nursing Assistant) for assistance in repositioning. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's hospital report dated 09/22/2024 documents he was admitted to the hospital due to suspicion of elderly abuse in light of family discovering bruising on his skin at the nursing home. There was a high suspicion for elderly abuse at nursing home after family found him in pain and were not notified of any falls drawing suspicion for abuse having received no reports of falls and found with evidence of rib fractures and humeral (upper arm) fracture. Patient was seen today by family member who noted upon hugging patient that he winced in pain and upon further evaluation family member found significant body bruising and shoulder deformity with no reported falls from nursing home which he has been residing for over 2 years. Family has high suspicion for elderly abuse at nursing home, of note he is on Eliquis for Deep Vein Thrombosis and prophylaxis (illness prevention) and has a history of falls. Patient is at his dementia baseline however seems uncomfortable due to pain. He is typically wheelchair bound and usually needs help with assistance to bathroom. Imaging revealed impacted right humeral (upper arm bone) fracture, and 10th and 11th rib fractures. R1 was observed with a small abrasion to his right knee and bruising on his right upper extremity. The facility's Final Abuse Investigation Report dated 09/27/2024 documents on 09/22/2024 while providing care staff observed bruising to R1's upper right arm. He was unable to provide any information about what the source of the bruise was. He was sent to the hospital for evaluation, and it was found via emergency room x-ray that R1 sustained an impacted right humeral (right upper arm bone) fracture, and nondisplaced fractures of the right 10th and 11th ribs; multiple interviews were taken from staff working during varying shifts from 09/21/2024 - 09/22/2024. Witness statement from V11 (Licensed Practical Nurse) dated 09/22/2024 documents on the evening of 09/21/2024 while passing medications after dinner time he observed R1 was in his room in his bed with his feet hanging over the foot of his bed. He was sliding down his bed and hanging his feet over the end of the bed. He stepped into the hallway and asked V14 (Certified Nursing Assistant) to assist him with repositioning R1. R1 denied any pain and he did not observe anything unusual during this interaction. Witness statement from V14 dated 09/22/2024 at 1 PM documents she was assigned to work with R1 on 09/21/2024 during the PM shift. She recalls assisting V11 (Licensed Practical Nurse) with repositioning R1 in bed that evening and observed R1's legs hanging off the bed when she entered the room. R1 did not exhibit any signs or indications of pain or discomfort during repositioning or throughout the remainder of her shift. Witness statement from V15 (Certified Nursing Assistant) dated 09/22/2024 at 11AM documents he worked during the day shift on 09/22/2024. V15 dressed R1 and brought him to the dining room, noticed R1 was guarding his arm but he did not show any signs of pain or distress. Witness statement from V12 (Licensed Practical Nurse) dated 09/22/2024 at 12 PM documents she was assigned to R1 on 09/22/2024. V12 was not aware of any incidents/accidents involving R1 during her shift or any other day. V12 provided R1 with his morning medications and did not notice him with any distressing or unusual behavior and did not observe him to show any signs of distress. V12 was then notified by the assigned CNA (Certified Nursing Assistant) that R1 was guarding his arm during ADL (Activities of Daily Living) care. Upon assessment R1 was found with bruising to his right upper extremity. Based on the type of injuries sustained, collected data, and staff interviews, it is believed that R1's injuries were most likely due to trauma sustained during the process of transferring himself into his bed. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's current care plan documents he is at risk for behavior symptoms related to dementia due to Parkinson's with behavior. Continues to reach for items on the floor and has a tendency to bump into doorway frame and bed frame. He has an alteration in his self-care of Activities of Daily Living related to decreased strength, endurance, balance, Parkinson's, Dementia, and cardiac issues with interventions including ambulating him from the bed to the bathroom on day and evening shifts. Encourage and/or assist to reposition frequently. R1 has impaired mobility related to Parkinson's and Dementia with intervention including guiding him to position his legs and place safety gait belt around his waist during transfer. R1 requires assistance with activities of daily living including bed mobility and transfers. R1 is at high risk for falls related to fatigue, weakness, current medication use, poor safety awareness, unsteady gait, disease process related to Dementia, history of falls, and stroke. On 10/08/2024 at 9:15 AM V19 (Family Member) stated he and another family member usually visit R1 every Sunday morning to have breakfast with him. V19 stated when he came to the facility on Sunday 09/22/2024 around 12:30 PM he found R1 in the common room where he's always seated with other residents. V19 stated as soon as he touched R1's arm R1 screamed louder than he ever heard him scream in his life and then saw bruising on him and noticed his shoulder had swelling and bruising. V19 stated he asked the nurse in the corner of the room what happened to his father, and she said we don't know what happened to your father. V19 stated he doesn't know how they got R1 dressed that morning. V19 stated he took his father R1 out of the common room and took him to his room and performed more of an assessment of him. V19 stated that's when he noticed R1 couldn't breathe and couldn't tolerate any touch to his mid-section when he attempted to palpate him. V19 stated R1's had swelling of his neck, deformity and swelling of his clavicle (collar bone), bruising to his upper shoulder area down through his back and arm just above his elbow. R1's arm was swollen, and he could not move his arm. V19 stated R1 was holding his right arm tight to himself and was using his other hand to hold his right arm. V19 stated he also found bruising on R1's hips on the right side as well as the left and he had an open avulsion (skin tear) below his right knee. V19 stated its possible they left R1 alone and he was not supposed to be left alone. V19 contemplated whether R1 fell or did somebody drop him. V19 stated no one has ever advised us of R1 having osteoporosis or any other conditions that make his bones vulnerable to breaking. V19 stated for someone R1's age, his injuries could be life threatening. V19 stated R1 needs constant supervision, and they usually place him in bed, and he stays there until the morning. V19 stated if R1 is sitting in his wheelchair, he has Parkinson's and will sometimes attempt to reach down to the floor and pick up something. V19 stated his father hasn't gotten up on his own in years now. V19 stated during the meeting on Monday after R1's incident they told him that the nurse on duty 09/22/2024 didn't see R1 fall but noticed his feet were hanging from the bed abnormally but they didn't think anything of it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/08/2024 from 2:02 PM - 3:20 PM V1 (Administrator) stated upon review of the facility's camera footage she observed on Saturday 09/21/2024 at 7:38 PM R1 self-propelled to his room. At 7:48 PM V11 (Agency Licensed Practical Nurse) entered R1's room. At 7:49 PM V11 called V14 (Certified Nursing Assistant) into R1's room and at 7:52 PM V11 walked out of R1's room. At 7:53 PM V14 walked out of R1's room. V1 (Administrator) stated the position R1 was found in after propelling himself to his room indicates he attempted to self-transfer. V2 (Director of Nursing) stated V11 told her he didn't really think much about the incident of how he found R1 positioned in his room. V2 stated when V13 (Nurse Supervisor/Registered Nurse) was notified of R1's bruises, she began investigating and there was no report. The morning nurse wasn't aware of any incident or accident that happened, and she looked at documentation and didn't find anything about R1. V18 (Restorative Nurse) stated a gait belt is required for transferring R1. V18 stated R1 cannot transfer himself from one surface to another and always needs someone there with him. V1 stated she didn't think at the time of R1's incident there was any communication about how R1 got into his bed. When asked by surveyor should V14 have attempted to determine how R1 got himself into his bed and in the position, V1 stated, yes, the expectation is that V11 should have done so. V2 stated the position R1 was found in could put him at risk for injuries with his legs hanging across the footboard and if they were positioned that way for some time there could be some pressure. When asked by surveyor if R1 should have been checked for injuries based on the position he was found in and the fact that he can't self-transfer, V2 stated yes, V14 should have. V2 stated the observation of R1 being found in an abnormal position by V11 should have been documented right away. V2 stated yes, the standard of care is that how R1 was found was an awkward situation and should have been documented. V2 stated V11 documented his observations of R1 after being asked by V13 (Nurse Supervisor/Registered Nurse) if there were any unusual incidents or observations of R1 the night before 09/22/2024. V2 stated the concern about R1 not being examined after being found in abnormal position by V11 would be he could have been injured. V2 agreed if V11 checked R1, he may have observed redness or any fresh scratches or skin tears. V2 stated if V11 had examined R1 and found any redness, scratches, injuries or openings then he could have further investigated and notified the doctor if necessary. V2 stated according to V11 and V14 there were no reported expression of pain from R1 when he was being repositioned and he was concerned about his shoes being in the wheelchair. V2 stated V11 should have investigated further as to what occurred with R1 because R1 is dependent on staff, he didn't put him in the bed and no one else put him in the bed. V2 stated V11 never contacted her and informed her that he found R1 in an abnormal position and if he did, she would have instructed him to assess R1 for injury because that's his safety and health. V14 stated on Saturday 09/21/2024 she observed R1 laying on his right side and his legs were lying across the top of the foot board of his bed. V14 stated R1's head and torso were closer toward the foot of his bed. V14 stated she did not place R1 in bed. V14 stated she did not have any concerns about how R1 got in the bed on his own. V14 stated no one else stated they placed R1 in the bed that night. V14 stated prior to V11 finding R1 in the bed he was sitting in the front of his room. V1 stated she observed R1 on the camera footage from 09/21/2024 sitting in front of his room right outside the doorway before propelling himself into his room. V14 stated R1 needs assistance transferring from one surface to another. V14 stated she wasn't concerned about how R1 got in his bed because she saw V11 with him and thought he put him to bed. V14 stated she didn't ask V11 if he put R1 in the bed and V11 did not mention to her that he found R1 in the bed already. The facility's Notification for Change of Condition policy received 10/08/2024 states: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility will provide care to residents and provide notification of resident change in status. Procedures 1. The facility must immediately: consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is: a. An accident involving the resident which results in injury and has the potential for requiring physician intervention.

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F 0689 Level of Harm - 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** 40718 Based on observations, interviews, and record reviews, the facility failed to prevent an accident by not ensuring R1 was adequately supervised based on his history of behaviors and accidents, mobility limitations, and health status which resulted in R1 self-transferring and sustaining multiple fractures. This failure applies to one (R1) of three residents reviewed for accidents/supervision. Findings include: R1 is an [AGE] year-old male with a diagnoses history of Parkinson's Disease, Dementia, Major Depressive Disorder, Muscle Wasting and Atrophy, Psychotic Disorder with Delusions, Diverticulitis, Cardiomegaly, Atherosclerotic Heart Disease, Encephalopathy, Malignant Neoplasm of Spinal Cord, and chronic kidney disease who was admitted to the facility 01/27/2020. On 10/02/2024 at 11:21 AM Observed R1 sitting in a wheelchair in the dining room. Observed R1 wearing a sling on his right arm. Observed R1's right arm covered in bruises and observed bruises on R1's left arm. R1's progress note created by V12 (Licensed Practical Nurse) dated 9/22/2024 at 12:30 PM documents he was noted with bruising and swelling to his right upper arm, he is unable to move extremity without pain. Abuse Coordinator notified. Note created by V13 (Registered Nurse) at 1:30 PM documents writer was notified that resident has a new bruise and swelling to right upper arm. Resident noted guarding right arm, not allowing writer to assess for range of motion. Called and spoke with V27 (Physician) with new orders to send resident to the ER for evaluation. R1's progress note created on 9/22/2024 21:27:28 by V11 (Agency Licensed Practical Nurse) documents note is a late entry for 9/21/2024 21:30; and states during rounds noted resident with legs hanging over the footboard of his bed, entered the room to observe and called CNA (Certified Nursing Assistant) for assistance in repositioning. R1's hospital report dated 09/22/2024 documents he was admitted to the hospital due to suspicion of elderly abuse in light of family discovering bruising on his skin at the nursing home. There was a high suspicion for elderly abuse at nursing home after family found him in pain and were not notified of any falls drawing suspicion for abuse having received no reports of falls and found with evidence of rib fractures and humeral (upper arm) fracture. Patient was seen today by family member who noted upon hugging patient that he winced in pain and upon further evaluation family member found significant body bruising and shoulder deformity with no reported falls from nursing home which he has been residing for over 2 years. Family has high suspicion for elderly abuse at nursing home, of note he is on Eliquis for Deep Vein Thrombosis and prophylaxis (illness prevention) and has a history of falls. Patient is at his dementia baseline however seems uncomfortable due to pain. He is typically wheelchair bound and usually needs help with assistance to bathroom. Imaging revealed impacted right humeral (upper arm bone) fracture, and 10th and 11th rib fractures. R1 was observed with a small abrasion to his right knee and bruising on his right upper extremity. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility's Final Abuse Investigation Report dated 09/27/2024 documents on 09/22/2024 while providing care staff observed bruising to R1's upper right arm. He was unable to provide any information about what the source of the bruise was. He was sent to the hospital for evaluation, and it was found via emergency room x-ray that R1 sustained an impacted right humeral (right upper arm bone) fracture, and nondisplaced fractures of the right 10th and 11th ribs; multiple interviews were taken from staff working during varying shifts from 09/21/2024 - 09/22/2024. Witness statement from V11 (Licensed Practical Nurse) dated 09/22/2024 documents on the evening of 09/21/2024 while passing medications after dinner time he observed R1 was in his room in his bed with his feet hanging over the foot of his bed. R1 was sliding down his bed and hanging his feet over the end of the bed. V11 stepped into the hallway and asked V14 (Certified Nursing Assistant) to assist him with repositioning R1. R1 denied any pain and he did not observe anything unusual during this interaction. Witness statement from V14 dated 09/22/2024 at 1 PM documents V14 was assigned to work with R1 on 09/21/2024 during the PM shift. V14 recalls assisting V11 (Licensed Practical Nurse) with repositioning R1 in bed that evening and observed R1's legs hanging off the bed when she entered the room. R1 did not exhibit any signs or indications of pain or discomfort during repositioning or throughout the remainder of her shift. Witness statement from V15 (Certified Nursing Assistant) dated 09/22/2024 at 11AM documents he worked during the day shift on 09/22/2024. V15 dressed R1 and brought him to the dining room, noticed R1 was guarding his arm but he did not show any signs of pain or distress. Witness statement from V12 (Licensed Practical Nurse) dated 09/22/2024 at 12 PM documents she was assigned to R1 on 09/22/2024. V12 was not aware of any incidents/accidents involving R1 during her shift or any other day. V12 provided R1 with his morning medications and did not notice him with any distressing or unusual behavior and did not observe him to show any signs of distress. V12 was then notified by the assigned CNA (Certified Nursing Assistant) that R1 was guarding his arm during ADL (Activities of Daily Living) care. Upon assessment R1 was found with bruising to his right upper extremity. Based on the type of injuries sustained, collected data, and staff interviews, it is believed that R1's injuries were most likely due to trauma sustained during the process of transferring himself into his bed. R1's current care plan documents he is at risk for behavior symptoms related to dementia due to Parkinson's with behavior. Continues to reach for items on the floor and has a tendency to bump into doorway frame and bed frame. He has an alteration in his self-care of Activities of Daily Living related to decreased strength, endurance, balance, Parkinson's, Dementia, and cardiac issues with interventions including ambulating him from the bed to the bathroom on day and evening shifts. Encourage and/or assist to reposition frequently. R1 has impaired mobility related to Parkinson's and Dementia with intervention including guiding him to position his legs and place safety gait belt around his waist during transfer. R1 requires assistance with activities of daily living including bed mobility and transfers. R1 is at high risk for falls related to fatigue, weakness, current medication use, poor safety awareness, unsteady gait, disease process related to Dementia, history of falls, and stroke. (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 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/08/2024 at 9:15 AM V19 (Family Member) stated he and another family member usually visit R1 every Sunday morning to have breakfast with him. V19 stated when he came to the facility on Sunday 09/22/2024 around 12:30 PM he found R1 in the common room where he's always seated with other residents. V19 stated as soon as he touched R1's arm R1 screamed louder than he ever heard him scream in his life and then saw bruising on him and noticed his shoulder had swelling and bruising. V19 stated he asked the nurse in the corner of the room what happened to his father, and she said we don't know what happened to your father. V19 stated he doesn't know how they got R1 dressed that morning. V19 stated he took his father R1 out of the common room and took him to his room and performed more of an assessment of him. V19 stated that's when he noticed R1 couldn't breathe and couldn't tolerate any touch to his mid-section when he attempted to palpate him. V19 stated R1's had swelling of his neck, deformity and swelling of his clavicle (collar bone), bruising to his upper shoulder area down through his back and arm just above his elbow. R1's arm was swollen, and he could not move his arm. V19 stated R1 was holding his right arm tight to himself and was using his other hand to hold his right arm. V19 stated he also found bruising on R1's hips on the right side as well as the left and he had an open avulsion (skin tear) below his right knee. V19 stated its possible they left R1 alone and he was not supposed to be left alone. V19 contemplated whether R1 fell or did somebody drop him. V19 stated no one has ever advised us of R1 having osteoporosis or any other conditions that make his bones vulnerable to breaking. V19 stated for someone R1's age, his injuries could be life threatening. V19 stated R1 needs constant supervision, and they usually place him in bed, and he stays there until the morning. V19 stated if R1 is sitting in his wheelchair, he has Parkinson's and will sometimes attempt to reach down to the floor and pick up something. V19 stated his father hasn't gotten up on his own in years now. V19 stated during the meeting on Monday after R1's incident they told him that the nurse on duty 09/22/2024 didn't see R1 fall but noticed his feet were hanging from the bed abnormally but they didn't think anything of it. On 10/08/2024 at 9:50 AM V13 (Nurse Supervisor/Registered Nurse) stated on 09/22/2024 she was told that R1 had a new bruise and asked her if she would go look at it. V13 stated she came in around noon and she was informed a few minutes after she arrived. V13 stated she went up to see R1. V15 (Certified Nursing Assistant) was trying to show her R1's arm. V13 stated she brought R1 into his room to tried and take R1's shirt off, but R1 wouldn't allow them to really look at because he was guarding his arm. V13 stated R1 had his arm bent towards himself just as if giving a hug with one arm and he would tighten it anytime you attempted to move his shirt. V13 stated she was trying to roll up the short sleeve of R1's right arm but he was tightening it. V13 stated she was able to see bruising in front and back of R1's arm, then she left the room and started making phone calls because she could tell something was wrong. V13 stated she called V1 (Administrator) because she is the abuse coordinator, then called V17 (Physician) and called and arranged for transportation for R1 to go to the hospital. V13 stated R1 wasn't yelling in pain and had a flat affect during this incident but he was guarding his arm. V13 stated R1 had no facial expressions which was surprising to her. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/08/2024 from 2:02 PM - 3:20 PM V1 (Administrator) stated upon review of the facility's camera footage she observed on Saturday 09/21/2024 at 7:38 PM R1 self-propelled to his room. At 7:48 PM V11 (Agency Licensed Practical Nurse) entered R1's room. At 7:49 PM V11 called V14 (Certified Nursing Assistant) into R1's room and at 7:52 PM V11 walked out of R1's room. At 7:53 PM V14 walked out of R1's room. V1 (Administrator) stated the position R1 was found in after propelling himself to his room indicates he attempted to self-transfer. V2 (Director of Nursing) stated V11 told her he didn't really think much about the incident of how he found R1 positioned in his room. V2 stated when V13 (Nurse Supervisor/Registered Nurse) was notified of R1's bruises, she began investigating and there was no report. The morning nurse wasn't aware of any incident or accident that happened, and she looked at documentation and didn't find anything about R1. V18 (Restorative Nurse) stated a gait belt is required for transferring R1. V18 stated R1 cannot transfer himself from one surface to another and always needs someone there with him. V1 stated she didn't think at the time of R1's incident there was any communication about how R1 got into his bed. When asked by surveyor should V14 have attempted to determine how R1 got himself into his bed and in the position, V1 stated, yes, the expectation is that V11 should have done so. V14 stated on Saturday 09/21/2024 she observed R1 laying on his right side and his legs were lying across the top of the foot board of his bed. V14 stated R1's head and torso were closer toward the foot of his bed. V14 stated she did not place R1 in bed. V14 stated she did not have any concerns about how R1 got in the bed on his own. V14 stated no one else stated they placed R1 in the bed that night. V14 stated prior to V11 finding R1 in the bed he was sitting in the front of his room. V1 stated she observed R1 on the camera footage from 09/21/2024 sitting in front of his room right outside the doorway before propelling himself into his room. V14 stated R1 needs assistance transferring from one surface to another. V14 stated she wasn't concerned about how R1 got in his bed because she saw V11 with him and thought he put him to bed. V14 stated she didn't ask V11 if he put R1 in the bed and V11 did not mention to her that he found R1 in the bed already. V2 stated the position R1 was found in could put him at risk for injuries with his legs hanging across the footboard and if they were positioned that way for some time there could be some pressure. V2 stated V11 should have investigated further as to what occurred with R1 because R1 is dependent on staff, he didn't put him in the bed and no one else put him in the bed.