| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145734 | A. Building<br>B. Wing | 10/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avantara Evergreen Park | 10124 South Kedzie<br>Evergreen Park, IL 60805 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from the wrongful use of the resident's belongings or money.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40066<br><br>Based on interviews and records reviewed the facility failed to ensure one resident's (R3) money was managed from her monthly portion paid to the facility. The facility collected a balance of $5,504.06 from R3's facility managed account and did not present an itemized record of services for the amount taken. This failure affected 1 of 3 residents reviewed for finances.<br><br>The findings include:<br><br>R3's diagnosis include but are not limited to Cerebral Infarction, Depressive Disorder, Diabetes, Heart Disease, and Dementia. R3 died on [DATE] and had resided at the facility since 2016. R3 was [AGE] years old.<br><br>Facility Abuse Report dated [DATE] states V19 (R3's POA), called and spoke to V13, Business Office Manager (BOM), regarding the trust account for R3 on [DATE]. V13 disclosed the amount in R3's account of $840.94. V19 said the amount should be more and V13 explained that in February 2023 the amount of $5504.06 should be applied to the balance of $6636.72. V19 states she never signed anything. Facility investigation states R3 still owed the facility $398.42.<br><br>R3's Power of Attorney dated [DATE] identifies V19, as 1 of 2 power of attorneys for R3.<br><br>On [DATE] at 12:19PM V19, R3's POA, said I mailed the facility the letter requesting they remove myself and my mother from the bills. V19 said I did not write, sign, or provide the second letter authorizing withdrawal of funds. V19 said I did not write it and that is not my signature. V19 said I did not come to the facility and I did not sign that letter. V19 said the facility has not given me an explanation on the bills or verbally for what was owed. V19 said the facility did not tell me that R3 had a balance due or still owed money when they closed her account. V19 said I did receive the $840.94 from the account. V19 said my mother, who is the other POA listed, did not consent either, she is not able to give consent anymore.<br><br>(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: 145734 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/16/2024 |
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| NAME OF PROVIDER OR SUPPLIER Avantara Evergreen Park | | STREET ADDRESS, CITY, STATE, ZIP CODE 10124 South Kedzie Evergreen Park, IL 60805 | |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On [DATE] at 11:39AM V13 said after R3 passed away V19 called and requested her balance to be used for funeral arrangements. V13 said V19 said R3 should have $6000 -$7000 in her account they were saving for funeral arrangements. V13 said I emailed corporate to review R3's resident trust account for the withdrawal in February 2023. V13 said corporate said V19 had singed to consent to withdraw for the owed balance. I called V19 and told her $5500 were withdrawn from her account for the old balance. V13 said V19 denied giving consent. V13 said I told V19 I would inform corporate office she is saying she did not give permission. V13 said V19 said someone forged her signature and she does not have a copy of the documents. V13 said V19 said she had never been in the facility to sign anything. V13 said V19 provided us a copy of the letter that she claims she sent us back in February 2023. V13 said I have been here since [DATE]. At 11:58PM V13 said the facility needs authorization to withdraw any funds. At 12:16PM the surveyor reviewed the signatures with V13 from four documents provided by the facility with V19's signature. V13 said the signature on the consent for withdrawal does not look the same to me. V13 said the first letter looks like an F to me and V13 signs with the P initial on the other documents. V13 said I don't see the P on the withdrawal signature. V13 said if I was doing this in a large amount, I would get a witness in case of something of this sort happened. V13 said we have no policy for this.<br><br>On [DATE] at 9:36AM V13 said when a resident is Medicaid pending the bill is still sent out with full bill amount. V13 said once Medicaid approves the resident, the patient responsibility amount can change. While reviewing the Transaction report for R3, V13 said R3 was paying an amount less than her portion, in the amount of $113.00, and the amount is still owed. V13 said the $113.00 shortage each month continued to accumulate. V13 said Medicaid determined R3's patient liability was $1097 for July, August and [DATE]. At 11:06AM V13 said R3's bills changed if she enrolled in other services, dental and vision plans. V13 said $113 was to pay for her dental and vision plan if she signed up for it. V13 said R3 wasn't paying her dental vision and she still owed it to the facility. V13 said that amount kept accumulating.<br><br>On [DATE] at 1:25PM V13 said the amount on the LTC Inquiry Results (TPL) form for the date ranges show the amount we are allowed to take out for resident care cost. V13 said the amount on the form should be the same as the amount on the resident bank statement withdrawal. V13 said that is how much medicaid has allowed them for their care, it includes dental and vision. V13 said the withdrawal amounts on the statement for R3 are different because she has elected to have vision and dental benefits.<br><br>On [DATE] at 11:41AM the surveyor asked V7, Administrator, why V13 was sent a check for her full amount if she still owed $398.42? V7 said V19 would not agree to that amount be taken out. V19 said they have to agree for us to take it.<br><br>On [DATE] at 2:05PM V13 presented a Cash Receipts Report for R3. V13 said we are going to refund $2156.00 related to the vision and dental benefits to V13 for R3's account.<br><br>Facility presented a letter regarding R3 dated [DATE] addressed to the financial department. Letter states V19 would like for R3's $5504.06 amount to applied to her back balance. Also, continue to deduct R3's $30.00 each month and apply towards the back balance until the balance is paid in full. There are 2 signatures on document, includes V19 and former BOM.<br><br>Review of R3 bank statements $30.00 not taken out.<br><br>(continued on next page) |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility presented four documents with V19's signature, witness certificate dated [DATE], certification for surrogate dated [DATE], and the withdrawal letter and a letter written by V19 requesting she be removed from the bill dated [DATE]. The signature on the withdrawal document that the facility alleges is V19 is not similar to the other two documents. The withdrawal consent is dated [DATE].<br><br>On [DATE] V7 Administrator said we were sending V19 collection letters for the balance owed.<br><br>R3's banking statement reviewed since [DATE]. Every month SSA Treas credit was made. Every month an amount, determined to be R3's care cost was withdrawn by the facility. After 2020 R3 had balance amounts between $4000.00 - $5000.00. The facility did not present collection letters requested during the survey on [DATE] or [DATE]. The facility was unable to present an itemized billing statements for the alleged BALANCE FORWARD $7894.72.<br><br>On [DATE] R3's banking statement description is Resident Advance Debit $5504.06.<br><br>The facility presented R3 billing statement dated [DATE]. The statement list BALANCE FORWARD $7894.72<br><br>The facility paid out $840.94 to V19 and did not deduct the alleged $398.42 owed as stated on the facility's IDPH (Illinois Department of Public Health) report.<br><br>Dental Insurance plan dated [DATE] notes a monthly premium of $199.36 for R3. Documents states, in part, I authorize the facility to disburse payment. Document was signed by R3. Vision Policy application dated [DATE] notes R3 monthly premium increased to $70.00. This amount totals $269.36, not $113.00.<br><br>The Resident Rights booklet provided by the facility states if you ask the facility to manage your money it may only spend your money with your permission. It must give you a current, itemized written statement at least once every three months. If your facility manages your money and you get Medicaid your facility must tell you if your savings come within the amount Medicaid allows you to keep. |

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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** 38796

Based on observation, interview, and record review the facility failed to ensure fall prevention intervention to include supervision/monitoring were implemented to reduce the risk of falling, failed to ensure residents were assessed and able to use assistive device safely to prevent falls and injuries. This affected six of six residents (R1, R2, R4, R5, R6, R8) reviewed for falls and safety. This resulted in R1, R2, R6, and R8 having fall resulting lacerations to the scalp, R4 being in a fall incident attempting to use an assistive device and sustained a left fibula fracture, and R5 bumping into open door using a motorized wheelchair and sustain a right and left tibia fracture.

Findings include:

1. R4 face sheet shows diagnosis of hemiplegia, hemiparesis following cerebral infraction affecting right dominate side, other lack of coordination, and history of falling. R4 MDS assessment dated [DATE] denotes in-part section C for cognition shows a score of 3 (cognitive impairment).

R4 incident report dated 9/11/24 denotes in-part writer summons to room by CNA, upon entering I (writer) observed resident sitting on floor in front of her closet. Prior to sitting in wheelchair near closet. Predisposing physiological factors- confused, gait imbalance. Predisposing situational factors- trying to stand without assist.

R4 fall risk evaluation dated 9/11/24 denotes in-part a score of 13 (high risk), R4 fall risk evaluation dated 9/29/24 denotes in-part a core of 18 (high risk).

R4 incident report dated 9/29/24 completed by V1 denotes in-part fall without injury, incident location, resident room. right at her residence bed alarm sounding upon entering residence room writer observed resident sitting on the edge of the bed holding her walker writer asked resident what she was trying to do, and resident stated she needed to use the restroom. While writer was assisting residents to the restroom, resident appeared to lose her balance, while assisting resident to the floor both the writer and resident fell resulting in resident falling on writer. Resident noted with non-skid socks on, room free of clutter. Call light in reach but not activated. Head to toe assessment completed no bleeding bruising or deformities noted at this time. Vitals assessed BP 110 / 60, heart rate 57, temp 97.6, blood sugar 100, respirations 18, O2sat 97% room air. Resident transfer back to bed via Hoyer lift, two staff assist, resident complaints of pain 0 of 10. Fall coordinator notified. Physician notified and orders received to send resident to (hospital name) hospital for further evaluation. Sister notified. Predisposing environmental factors none of the above. Predisposing physiological factor; use of blood thinners, diabetes, balance poor/balance disorders. Predisposing situation factors: ambulating with assist, recent room change, using walker. Agencies/people notified; DON/designee and family.

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R4 post fall investigation/ RCA (root cause analysis) dated 9/30/24 denotes in-part observed fall with injury, location- resident room, did incident result in injury-yes, type of injury- left closed fibula fracture. Activity at time- ambulating with staff, mental status- alert and orient 2-3, poor safety awareness, is resident at risk for falls- yes, does resident have history of falls- yes. Root cause analysis- R4 is a [AGE] year old female with diagnosis of bipolar disorder major depressive disorder hemiplegia and hemiparesis following cerebral infarction affecting right dominant side alert and oriented times 2 to 3 BIM score of three and a stand and pivot in transferring. R4 was changed in bed by CNA at 4:00 PM. The nurse responded to R4's bed it alarm sounding when the nurse entered the room R4 was observed sitting on the edge of the bed. When the nurse asked R4 what she was trying to do R4 stated she had to use the bathroom. The nurse was assisting a resident to the bathroom using a gate belt when R4 lost her balance the nurse eased the resident to the floor both resident and a nurse fell resulting in falling on top of the nurse resident was transferred out for evaluation per MD orders facility anticoagulation protocol. Therapy to evaluate and treat.<br><br>On 10/4/24 R4 said the nurse was helping her to bathroom and she fell . R4 said she broke her ankle.<br><br>On 10/8/24 at 11:48am V2 (CNA) said he has worked with R4, V2 said he has ambulated R4 using her walker. V2 said when he uses the walker, he put the wheelchair behind R4 just in case she gets weak and fall. V2 was asked how is R4 safe to use a walker if she might get weak and fall. V2 said that's why I use the wheelchair too, it just depends on what she needs. V2 said he was R4's aide when R4 had a fall on 9/11/24. V2 said he observed R4 on the floor in her room sitting on her buttocks, R4 told him her legs got weak and she fell , when she was at the closet.<br><br>On 10/8/24 at 10:21am V1 (Nurse) said she heard R4 bed alarm sound, she went in the room and observed R4 sitting at the bedside with a walker. V1 said R4 stated she wanted to go to the restroom, V1 said she offered to help R4. V1 said she put a gait belt around R4 waist, she stood R4 up, R4 had the walker in front of her, as R4 was ambulating R4 lost her balance a fell backwards toward her, which caused her to fall with R4. V1 said R4 landed on top of her. V1 said R4 used a walker for ambulating.<br><br>On 10/8/24 at 1:14pm V9 (Fall coordinator) said she conducted the fall investigation for R4 fall, date of fall was 9/29/24. V9 said R4 had a fall while ambulating to the restroom. V9 said the root cause of R4 fall was that R4 was ambulating and fell . V9 said R4 was not assessed to use a walker, V9 said R4 ambulation status was not assess or evaluated. V9 said she had never observed R4 ambulating. V9 said R4 had a room change and she believes that walker was left in the room. V9 said she called R4's family and the said they did not give R4 that walker. V9 said R4 should not have a walker, that's why she removed the walker when she found out staff was using that walker for R4. V9 said she was not aware that staff was ambulating R4, she was not aware that staff was ambulating R4 with a walker. V9 said R4 family did not want R4 to have any functional decline. V9 said she did not refer R4 to therapy for functional decline until R4 had the fall on 9/29/24.<br><br>On 10/8/24 at 2:01pm V11 (Restorative Director) said staff should not ambulate a resident without having an assessment completed. V11 said staff should not be ambulating R4 with a walker if R4 was not assessed to use a walker by therapy. During a follow up interview V11 said R4 did not receive an evaluation or an assessment from restorative after the fall for 9/11/24. R4 was referred to physical therapy after the 9/29/24 fall with injury.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 10/11/24 at 1:59pm V22 (care plan coordinator) said she initiated R4 plan of care and the assistive device for ambulating should be a gait belt, V22 said she don't know why she did not document what assistive device that R4 uses.<br><br>V1 (Nurse) witness statement denotes in-part, resident was being assisted by staff to restroom when resident lost her balance and was shaky and fell down with staff member.<br><br>R4 current plan of care presented by V8 (Director of Nursing) denotes safety: fall admitted in unit was observed she is high risk for falls related to current medications use, poor safety awareness, unsteady gait, disease process: sarcoidosis, CHF, alcohol use with withdrawals cognitive impairment, gait problems, such as unsteady gait, even with mobility aid or personal assistance, slow gait, takes small steps, takes rapid steps or lurching gait, hemiplegia/hemiparesis, history of falls. Contributing factors: physical/function status, ambulation; needs physical and verbal assist, poor standing balance, unsteady gait, needs assist in transfers, on and off pain/ discomfort, incontinence, needs reminders: safety awareness, prev (prevention) of fall reminders to use call light. R4 will participate during safe transfer technique with 1-2 staff assistance from bed to chair w/o (without) resistance, w/o undetected, unrepeated incident of fall. R4 need to wear nonskid socks/shoes, proper footwear, bed locks/WC (wheelchair), locks engage for transfer, use assistive devices during ambulation to prevent falls, skilled rehab therapy eval and treatment as indicates, ensure call light, phone and supplies within reach, keep mostly needed items within reach, ensure room is clutter free and dry. SPOST (status post) fall initial intervention5/3/24 sent to hospital for eval, signage (precaution) floor mat (1), bed alarm, restorative to evaluate/referral, therapy eval.<br><br>R4 hospital records dated 9/30/24 denotes in part clinical impression closed fibula fracture.<br><br>Facility falls occurrence policy with last revised date of 7/26/24 denotes in-part it is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place, and interventions are reevaluated and revised as necessary. The fall assessment form will be completed by the nurse or the falls coordinator upon admission, quarterly, significant change and annually. Those identified as high risk for falls will be provided fall interventions. An incident report will be completed by the nurse by the nurse each time a resident fall. The falls coordinator will review the incident report and may conduit his/her own fall investigation to determine the reasonable cause of fall. The nurse may immediately start interventions to address falls in the unit even prior to the Fall Coordinator investigation. Ultimately, the falls coordinator may change the interventions provided by the nurse if the falls investigation identifies a more appropriate intervention for the individual.<br><br>Facility care plan policy with last revised date of 7/26/24 it is the policy of the facility to ensure that all care plans including baseline care plans are in conjunction with the federal regulations. Comprehensive care plan must be developed after the comprehensive assessment of the resident.<br><br>2. R6 face sheet shows diagnose of history of falling, unspecified dementia. R6 MDS dated [DATE] denotes in part, BIMS score of 7 (cognitive deficits). Section GG for functional abilities and goals denotes toileting hygiene: 03 (partial to moderate assist).<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R6's final incident report to the department dated 9/17/24 denotes in-part, diagnosis COVID, hypertension, anemia, hyperlipidemia, atherosclerotic heart disease, atherosclerotic coronary artery bypass graft, GERD, prostate hyperplasia, non-infective gastroenteritis colitis, type 2 diabetes mellitus, COPD, dementia. R6 was observed lying on the floor near his bedside. Body assessment was completed, resident noted with small cut to the left side of his head. Area was cleansed with normal saline and dry dressing applied. Pain medication administration per physician order. Range was limited as patient did not want to move. BP (blood pressure) 148/76, P (pulse) 77, R(respiration) 19, T(temp) 97.6, 02 sat 95%. Physician was notified. Resident transported to hospital for further evaluation. R6 readmitted back to the facility with three staples to the left side of his head. No additional injuries noted. The plan of care has been reviewed and updated to address the resident's needs. Injury: yes, 3 staples to left side of head. When interviewed R6 stated I got up to go to the bathroom by myself I didn't push the call light for help because I thought I could make it by myself. I took a couple steps and lost my balance landing on floor. Based upon further investigation, staff interviews, and medical records review. Prior to the incident at 11:30 PM the assigned CNA did rounds and noted the residence in the dry and resting comfortably. At 1:50 AM upon rounds the nurse heard R6 calling out for assistance, when she entered the room, she noted R6 laying on the floor his incontinence brief was open and urine on the floor. Body assessment was completed. Resident sustained a small cut to left side of his head. Area was cleaned with normal saline and dry dressing applied. Pain medication administered. V9 was asked if R6 had the mental capacity to remember to pull call light before going to the bathroom. V9 said R6 knew how to use the call light. V9 was asked does R6 have the mental capacity to understand safety concerns and that he could injury himself if he did not press the call light and wait for staff to coma and take him to the bathroom. V9 did not respond.<br><br>Facility incident report dated 9/11/24 denotes in-part upon doing rounds resident noted on the floor near his bedside with his brief off and urine on the floor. Prior to the incident resident was noted resting in bed comfortably with no distress noted. Injury type: top of scalp. Pain:8. Oriented to person. Wet floor, incontinent, weakness/fainted, altered mental status, dementia related behaviors, fragile skin. Physician, ombudsmen, and family notified.<br><br>Facility post fall investigation/ RCA (root cause analysis) R6 is an [AGE] year-old male with diagnosis of unspecified dementia, history of falls, COPD, type 2 diabetes, alert, and oriented x2-3 with periods of confusion. R6 was observed by CNA in the bed at 11:30pm, resting comfortably and dry. R6 stated he had to go to the bathroom and did not pull his call light for assistance, he got out the bed independently, took a couple of steps and that's when he fell on to the floor. R6 couldn't remember if he had any socks or shoes on and 45 minutes prior to the incident, R6 was seen in bed asleep by the nurse.<br><br>R6 admission/ readmission assessment shows call light evaluation- is the resident cognitively able to use the call light, no is checked.<br><br>R6 fall risk assessment dated [DATE] shows a score of 17 (high risk).<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 10/10/24 at 10:02am V9 (Fall coordinator) said R6 was admitted on [DATE], R6 fell on [DATE]. V9 said R6 was admitted for rehab and due to a respiratory infection. V9 said R6 was alert times 2 (person, place) with episodes of confusion. V9 said R6 root cause of his fall was due to R6 had a fall because he got up to go to the bathroom. V9 said the incident happened around 1:50am. V9 said R6 had a sitter that was provided by the family during the day. V9 said the unit Nurse's informed her that R6's family request that R6 have a chair alarm and that R6 had previous falls at home. V9 said she provided R6 with the chair alarm. V9 said she did not follow up with the family to inquire about R6 fall history at home and why the family was requesting a chair alarm. V9 said the nurse did not give her any information regarding R6 fall history. V9 said she don't know if the nurse asked the family about R6 fall history. V9 did not respond when asked if she asked R6 about his fall history at home. V9 said she don't know if R6 was getting up at night at home when his falls occurred. V9 said she should have inquired further about R6 fall history at home and that would have helped her to implement fall interventions for R6. V9 was asked why did R6 have a sitter, V9 did not respond. V9 said the aides do rounds every two hours. V9 said R6 daughter did not want R6 getting out of bed. V9 said she did not ask R6 daughter why she did not want R6 getting in out of bed. V9 said she don't know if it was related to R6 having falls.<br><br>On 10/10/24 at 3:13pm V30 (LPN) said she initiated R6 plan of care for falls, V30 said R6 informed her that he had previously fell at home. V30 said she did not ask R6 about his fall history, she did not gather further information to determine what R6 was doing when he fell at home. V30 said next time she will ask more questions. V30 said Resident rounds are done every two hours or as needed. V30 said incontinent care is completed during resident rounds. V30 said R6 has dementia. V30 did not respond when will R6 remember to use the call light to call for assistance.<br><br>V31 statement presented by the facility denotes in part I started my rounds at 1130pm, Resident was in bed resting comfortably, bed in lowest position call light within reach. Around 150am while doing rounds again, I heard the nurse call for assistance. When I entered the room, I observed the resident laying on the floor diaper was opened and urine on the floor and nurse assessing the resident.<br><br>V31 statement included in facility investigation does not show that she anticipated R6 needs for using the restroom.<br><br>V31 (CNA) was called and texted on 10/10/24 at 1:45pm, 10/16/24 at 10:34, for an interview, V31 did not respond to call or text message.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R6 care plan with initiated date of 9/10/24 denotes in-part safety/fall, admitted in the unit on 9/9/24 and was observe that R6 is at risk for fall/ safety injury due to multiple medical functional, mental, and physiological conditions resulting to be at risk for falls. Contributing factor's physical function status, ambulation; need assistance in walking, poor sitting balance, poor standing balance, unsteady gait, needs assistance in transfer, pain, and discomfort. Forgetful needs reminders cues, poor safety awareness regarding prevention to use call light. Call for assistance, periods of restlessness and agitation. Newly admitted to the facility, new environment, admitted with recent decline in function, multiple aches and pains, discomfort. Provide privacy to the resident, staff to make sure bed in a lowest possible position, staff to give friendly approach to resident and anticipate needs, provide safe therapeutic environment (free from clutter), manage pain for comfort and facilitate free movement. Remind me to ask for assistance. Reorient me to how to use the call light if necessary. Please make sure that my call light is within my reach and encourage me to use it for assistance as needed. I would like staff to address my needs with prompt response to all request for assistance. Chair alarm, bed alarm, fall mat, vision/sound monitor.<br><br>R6 hospital records dated 9/11/24 denotes in [AGE] year-old male with history of CAD, COPD, dementia presents for evaluation for unwitnessed fall. Physical exam 2 cm left posterior partial scalp laceration. Laceration repair, two staples.<br><br>3. R5 diagnosis hemiplegia, hemiparesis following a cerebral infraction, cerebral ischemia, difficulty in walking, optic neuritis, repeated falls, retinal ischemia, glaucoma of right eye, primary open angle glaucoma of left eye severe stage, corneal edema, diabetes mellitus type 2, pseudophakia of both eyes, branch retinal artery occlusions of right eye, ocular ischemic syndrome. R5 MDS dated [DATE] denoted visual impairment. R5 MDS section for functional abilities dated 8/21/24 denotes for mobility devices is documented for no for wheelchair use (manual or motorized). Does the resident use a motorized wheelchair or scooter, no is documented. R5 MDS dated [DATE] section GG for mobility devices denotes in-part check all that were normally used in the last 7 days, none of the above were used (cane/crutch, walker, wheelchair, limb prosthesis).<br><br>R5 facility final incident report to the State department dated 9/13/24 with date of incident 9/9/24 denotes in-part osteoporosis osteoarthritis, chronic pain, hyperlipidemia, polyneuropathies, anal fistulas. Other type of incident not listed here: wheelchair incident. Location of incident 500-unit hall. R5 was transporting himself in his electric wheelchair down the hall as he turned his wheelchair around to go in the opposite direction R5's wheelchair rolled over his right foot before R5 was able to stop his wheelchair. Body assessment was completed resident noted with a small abrasion to the right inner ankle. This area was cleansed with normal saline and dry dressing applied. Pain medication administered per physician order. Range of motion within normal limits. B/P (blood pressure) 127/74, P90, R18, T97.6. Physician was notified new orders received for state X-ray of right ankle right foot. Responsible party was notified. Resident transported to hospital for further evaluation and subsequently admitted . The plan of care would be addressed upon readmission. Injury: yes. Acute nondisplaced fracture at the visualized distal tibia and fibula. Final investigation/conclusion- R5 was transporting himself in his electric wheelchair down the hall as he turned his wheelchair around to go in the opposite direction he bumped into the wall, R5 accidently rolled over his right foot with his wheelchair. When interviewed, R5 stated I was rolling down the hallway when I bumped into the wall. I didn't feel my wheelchair rolling over my foot. I didn't even know I rolled over my foot until the staff came to assist me. Resident transported to hospital where he was subsequently admitted with right distal tibia and fibular shaft fractures. The plan of care will be addresses upon readmission.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | V18 statement included with facility investigation denotes in part, I (V18) while rounding on the 500 unit heard a boom. I observed the resident R5 right foot under his motorized wheelchair. I instantly called for help from my nurse. I told R5 to stop so we could help him because his foot was under his wheelchair. R5 told me he didn't need any help and proceeded to move his wheelchair backward rolling over his right foot again. After that my nurse arrived along with additional help. When I asked R5 where he was going because this is not his unit, he proceeded to tell me that he was just riding down the hall trying to turn around.<br><br>V29 statement denotes in part, R5 stated he was riding in his wheelchair and his leg dropped and he ran over his foot.<br><br>R5 physical therapy discharge summary, with discharge date of [DATE] denotes in-part current reason for referral patient referred to skill PT (physical therapy) intervention for motorized wc (wheelchair) mobility training. LTG (long term goal) 2 IND (independent) with manual wc (wheelchair) but is SUP (supervision) with motorized (wc) wheelchair management and operations for safety. Education and instruct on safety precautions and how to maneuver his motorized wc. Performed really well but will need SUP with his wheelchair to better carry over of safety instructions regarding motorized wheelchair. Treatment results communicated with interdisciplinary team. Discharge recommendations- recommend to continue with restorative nursing therapy for wc (wheelchair) management.<br><br>R5 incident report dated 2/6/24 denotes in part writer was notified by resident that he hit his leg on the wheelchair ramp with his wheelchair after his appointment at u of c medicine. R5 stated he was moving his wheelchair into the medicar and ran his wheelchair into the ramp and hit both his legs when getting in the van.<br><br>On 10/9/24 at 10:58am V18 (CNA) said she was in a resident's room, when she heard a boom sound and she came out the room, and observed R5 in his motorized wheelchair, the wheelchair against the door. V18 said R5 hit the one of the double doors that was open. V18 said R5 right foot was observed behind the wheel of his motorized wheelchair. V18 said she said told R5 wait let me help you R5 said he did not need help and R5 rolled over his right foot again, trying to turn around. V18 said she summons the nurse and the nurse arrived to assess R5. V18 said R5 complained of pain after rolling over his foot the second time. V18 said R5 leg rest was up and R5 right foot was behind the leg rest, and behind the wheels of the chair. V18 said she had never seen R5 leg in that position. V18 said she is familiar with R5, R5 would complain of visual problems during activities. V18 said she used to be an activity aide. V18 said she believed R5 had trouble seeing. V18 said she don't recall if R5 wore glasses. V18 said she don't recall if R5 had on glasses on the day of the incident. V18 said she summons the nurse.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 10/9/24 at 2:38pm V23 (Physical therapist) said R5 was referred to physical therapy for wheelchair training. V23 said he don't know why R5 needed wheelchair training. V23 said R5 did mention to him that he could see shadows and could not see details V23 said he did not report to anyone in the facility that R5 complain of not being able to see details and saw shadows. V23 said he dropped the ball. V23 said R5 could not see the power on and off button on the wheelchair, R5 was able to steer the wheelchair. V23 said he worked on steering, turning, and going around tables with R5. V23 said the recommendations upon discharge was independence with manual wheelchair and supervision for motorized wheelchair. V23 said supervision for R5 was that staff should walk along side R5 while he steers the wheelchair. V23 said it's for safety so that R5 does not bump into things. V23 said when the staff walk alongside R5 it's considered contact guard and not one on one. V23 said R5 could not see the power on/ off button on the wheelchair. V23 was asked how is R5 safe to use a motorized wheelchair if he saw shadows/ visual impairment and needed someone to walk along side of him. V23 did not respond. On 10/10/24 V23 followed up with surveyor and said R5 was safe to use a motorized wheelchair.<br><br>On 10/9/24 at 1:52pm V11 (Restorative Nurse) said R5 was referred to physical therapy for wheelchair management and safety in May 2024. V11 said R5 was not in any restorative programs for motorized wheelchair safety after discharging from physical therapy in June 2024. During a follow up interview V11 said R5 sustained an injury in his motorized wheelchair, that's why he was referred to physical in May 2024.<br><br>On 10/11/24 at 2:30pm V8 (Director of nursing) said eye contact was the intervention implemented to reduce the risk of injury for R5, when R5 used his motorized wheelchair. V8 said there was staff present when R5 ran into the door with his motorized wheelchair. V8 said the eye contact was an effective intervention for R5. V8 was asked how was eye contact an effective intervention for R5, and R5 ran into an open door and broke his right leg. V8 said the staff could not get to R5 fast enough. R5 previous incident reviewed with V8, V8 discussed R5 bumped into the ramp of the vehicle and injured his left leg. R5 history of visual impairment was discussed with V8, V8 said R5 could see. V8 was asked how did R5 run into an open door if he did not have any issues with his vision. V8 said it was an accident, accidents happen. V8 said R5 did not go to his appointment to check his visual field. V8 omitted reason why R5 did not go to his appointment to check his visual field. V8 was asked why did R8 need an exam to check his visual field if he did not have visual impairment. V8 said residents have rights, and R5 wanted to use his motorized wheelchair. R5 physical therapy recommendation reviewed with V8 denoting that R5 was independent with manual wheelchair and supervision with motorized wheelchair. V8 continue to say R5 was a proud man and he begged her to use his motorized wheelchair, after the motorized wheelchair was removed from R5 use after R5 incident of running into a vehicle ramp in February. V8 said R5 did not have a care plan in place for the motorized wheelchair, and R5 did not have a care plan in place for the supervision while using a motorized wheelchair. V8 said she does not know why R5 did not have a care plan in place for the motorized wheelchair and supervision.<br><br>V8 omitted discussing risk and benefits with use of motorized wheelchair for R5. V8 suggest surveyor request the consultation for R5 optometrists visit.<br><br>R5 after visit summary from the eye clinic shows R4 had an appointment on 8/14/24 for visual field and return appointment for the eye doctor. V8 said R4 did not go to the follow up appointment with the eye doctor and the visual field.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R5 hospital records dated 9/9/24 denotes in part comminuted right tibia shaft fracture, comminuted right distal tibia fibula fracture, comminuted left tibial plateau fracture.<br><br>Facility care plan policy with last revised date of 7/26/24 it is the policy of the facility to ensure that all care plans including baseline care plans are in conjunction with the federal regulations. Comprehensive care plan must be developed after the comprehensive assessment of the resident.<br><br>40066<br><br>4. R1 diagnosis include but not limited to Alzheimer's Disease, History of Falling, Unsteadiness On Feet, Repeated Falls, Scoliosis, Age Related Osteoporosis, Dementia, Mood Disorder, Generalized Anxiety Disorder.<br><br>Fall with Injury report dated 9/17/24 stated R1 observed laying on floor. Facility Final Incident Report stated 9/25/24 states R1 transported to hospital for evaluation. R1 return to the facility with 8 sutures to forehead and a closed nondisplaced fracture of second metacarpal bone of right hand.<br><br>R1 fall without injury dated 7/16/2024 notes R1 on the floor. R1 stated she was trying to transfer herself from wheelchair to bed. Root cause analysis states R1 was trying to get back in bed.<br><br>On 10/5/24 at 10:41AM R1 in regular wheelchair, no pommel cushion, R1 wearing black slacks. R1 crescent shape bruise, yellow/light blue under right eye, right arm dressed in what looks like a white ace wrap.<br><br>On 10/8/24 at 11:05AM V3, Registered Nurse (RN), said on 9/17/24 R1 was in the wheelchair. V10, CNA, said she got R1 up for lunch and she was eating in her room. V3 said V10 said she left the room to care for another patient. V3 said V10 said she left R1 alone about 10 minutes. V3 said R1 said she did not know what she was trying to do when she fell . V3 said R1 probably fell forward. V3 said R1 was a resident at risk for falls.<br><br>On 10/8/24 at 12:22PM V10, Certified Nursing Assistant (CNA), said on 9/17/24 I got R1 up for lunch and sat her at the side of the bed, with her tray table. V10 said after R1 ate I picked up her tray and went to the bathroom and then I stopped by another resident's room. V10 said in that time a co worker came and told me R1 was on the floor. V10 said the Nurse and coworker were in R1's room when I got there. V10 said when I left the room R1 had been sitting in the wheelchair. V10 said R1 had one cushion in her wheelchair at the time. V10 said I was in the room with R1 while she ate and after I got her tray I left her alone. V10 said I am not sure if R1 could sit in her room alone. V10 said I knew she was a fall risk.<br><br>On 10/8/24 at 12:09PM V6, CNA, said R1 has confused memory. V6 said R1 is a two person assist for transfer and she can be resistant. V6 said R1 can stand. V6 said I would not recommend R1 be left in her room in her wheelchair alone because she tries to get up unassisted. After interview V6 showed the surveyor R1 sitting on royal blue pommel cushion during meal. Surveyor observed R1 also sitting on black wheel chair cushion. V6 with ace bandage on right wrist. (R1 had not been on this cushion during earlier observation.) At 12:55PM the surveyor observed R1 with only the one blue pommel cushion, the black one had been removed.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 10/8/24 at 1:03PM V9, Fall Coordinator, said R1's intervention since the July fall is to not leave her alone in the room when in her wheelchair. V9 said R1's 2nd fall (9/17/24) they left her in the room and when staff returned R1 was on the floor. V9 said they should have taken R1 to activity and not left her alone in her room. V9 said we place the interventions on the care plan. V9 said I don't put the dates on the careplan interventions.<br><br>R1 fall report on 7/16/24 stated R1 mental status confused, alert and oriented times one, poor safety awareness. R1 attempting to stand/transfer without assistance. Root cause analysis of fall states R1 stated she was trying to get back in bed when she fell .<br><br>R1's safety fall care plan initiated on 9/12/22 includes risk factors of poor sitting balance, poor standing balance, poor safety awareness, unsteady gait, and needs assistance in transfer. Interventions dated 9/12/24 include therapy evaluation, floor mats, pommel cushion.<br><br>R1's hospital emergency department record dated 9/17/24 reads, noted to have large laceration to head. Laceration repair performed to 3cm laceration on forehead, 8 sutures.<br><br>R1's hospital emergency department record dated 9/19/24 states R1 presenting for evaluation of right hand pain. Sent back for evaluation of right wrist pain that has been going since her fall 2 days ago. Right wrist and right hand x-rays an acute non [TRUNCATED] |