STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145334	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rivaya Care of Des Plaines	9300 Ballard Road Des Plaines, IL 60016

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 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** 40987 Based on interview and record review, the facility failed to follow their policy on incident reporting within twenty-four hours of an unwitnessed fall with serious harm or injury to a resident to IDPH Illinois Department of Public Health and provide a final summary completed within 7 days. This failure applies to one (R57) of 1 resident reviewed for reporting of falls. R57 was admitted to the hospital with a left comminuted (multiple bone breaks) femur fracture with surgical intervention. Findings include: R57 is a cognitively impaired resident with diagnoses including but not limited to End Stage Renal Disease, Major Depressive Disorder, Dependence on Renal Dialysis, Other Abnormalities of Gait and Mobility, Lack of Coordination, Long Term (Current) Use of Anticoagulants, Reduced Mobility, and Weakness. R57's MDS Minimum Data Set (Comprehensive Assessment) dated 05/24/24 documents a brief interview for mental status score of 4 out of 15. A score of 0-7 indicates severe cognitive impairment. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(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	On 09/25/24 at 02:25 PM, V1 Administrator was asked about R57's fall incident and report to IDPH Illinois Department of Public Health. V1 said, R57 fell during the daytime, and she complained of pain. X-ray was ordered, technician came the next day, and the results came at midnight. She fell on a Wednesday and the results came between Thursday night and Friday morning. Based on the results of the x-ray relayed to the V20 NP R57 was transferred to the hospital. On the results there was a fracture, it was old or healing. We still investigated what happened with the fall. We contacted the family. I spoke with the daughter and son. I found out from V5 Restorative Nurse on Monday or Tuesday that R57 was going to have surgery for a hip fracture. V5 is the fall program coordinator and fall investigator. I sent her to the hospital for further evaluation. It was a recommended procedure for R57 to have surgery. This is a fall with a serious injury. We concluded the investigation that she had an accidental fall. We relied on the portable x-ray result. We still had to send her out to the hospital because there was an order to be sent to the hospital. The hospital conducted its own evaluation and confirmed the fracture, that's why she had the surgery. I should have reported it because she had a fall with injury. The investigation was with me, V5 Restorative Nurse, V23 [NAME] President of Operations, she's a nurse, and V22 Infection Preventionist. It was a group decision not to report. V1 said, A few days after the fall we decided we are not going to report because it was our honest opinion that the fall wasn't reportable based on the old or healing fractures. We are terminating our contract with the portable x-ray company. We cannot deny the surgery. The hospital report doesn't say the fracture was old. R57's 07/17/24 at 11:30 AM fall report #1635 by V8 RN Registered Nurse states in part: Staff member from maintenance notified NOD (nurse on duty) that resident was on the floor. Upon arrival in resident's room, NOD noted resident sitting on the side of the bed. Resident stated, I was trying to sit on the side of the bed and lost my balance while trying to get up. Was this incident witnessed: N (No). Immediate action taken: Head to toe assessment done, no injury noted, able to move all extremities at baseline, VS (vital signs) taken and recorded, resident with complaint of pain on both thighs, Tylenol 650mg (milligrams) PRN (as needed) administered. Resident denies hitting head at this time. V20 NP Nurse Practitioner notified with order for x-ray of BIL (bilateral) hip and pelvis, left femur and left elbow. Order confirmed and carried out. Notified POA (Power of Attorney) via voicemail as cell phone wasn't picked up. Ongoing neurological check and 72 hour post monitoring initiated. Injury type: No injuries observed at time of incident. Level of Pain Numerical: 4 Level of Consciousness: Alert. Mobility: Bedridden. Mental Status: Oriented to person and place. Predisposing physiological factors: Incontinent, Weakness. Root cause: Resident attempted to self-transfer out of bed by reaching for the privacy curtain and lost her balance. The portable x-ray company's date of service for R57 states in part 07/18/2024 x-ray of the pelvis and bilateral hips, five views. Impression: 1. Impacted left subcapital femoral neck fracture deformity, of unknown age. 2. Healed or healing left inferior pubic ramus fracture. The portable x-ray company's date of service for R57 states in part 07/18/2024 x-ray of the left femur, AP (anterior to posterior) and lateral. Impression: 1. Subcapital left femoral neck fracture deformity, of unknown age. 2. Osteopenia. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R57 was hospitalized on [DATE] through 07/31/2024 with a diagnosis of closed fracture of the left hip. The physical exam for her musculoskeletal area states in part: left hip restriction of range of motion due to pain. The 07/19/2024 hospital CT Computed Tomography Scan of the pelvis without contrast indicates final result 1. Comminuted, mild to moderately displaced left sacral ala fracture, extending to the left sacroiliac joint. Additional comminuted. mildly displaced fracture of the left posterior superior iliac spine, also extending to the sacroiliac joint. Suspected mild left sacroiliac joint diastases. 2. Comminuted, mildly displaced fractures of both superior and inferior pubic rami. Additional mildly displaced fractures of both acetabular and anterior columns. 3. Mildly displaced and impacted fracture of the left femoral neck, possibly Basi-cervical. 4. Focal angulation of the right femoral head-neck cortex may represent a nondisplaced fracture. The assessment and plan indicate left hip fracture: patient has been evaluated by orthopedics plan for surgical intervention today. The preoperative diagnosis states in part 1. Left displaced femoral neck fracture. On 07/23/24 R57 had Left Hip Arthroplasty (a surgery to restore the function of a joint. The joint is replaced, remodeled, or realigned.) The revised 7/14 Reporting of Unusual Occurrences Policy states in part: Purpose: To provide a process for the reporting and reviewing unusual occurrences. Responsible Party: Administrator, DON (Director of Nursing), Professional Nursing Staff Guideline: 4. The resident will be evaluated after the occurrence to determine injury. The evaluation that is done is based on the occurrence and documented in the progress notes. 7. The DON and Administrator will review all incidents. 8. If the incident report is serious, by which there is serious harm or injury to the resident it will be reported to IDPH Illinois Department of Public Health within 24 hours and a final summary completed in 7 days.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34516 Based on observation, interview and record review, the facility failed to follow manufacturer's instructions for the proper operation and functioning of the facility's pressure relieving air mattresses for 4 residents (R54, R18, R41, R121) in the sample of 28 reviewed for pressure ulcer prevention and management. Findings include: 1. R54 is a cognitively impaired [AGE] year old with multiple pressure ulcers to the sacrum, buttocks, and posterior head. On 9/23/24 at 10:30 AM, R54 was observed in bed asleep on top of a specialty air mattress prescribed by the physician. The air-mattress was observed on static mode and did not provide the alternating pressure needed to intermittently off-load pressure from R54's wounds. The weight setting on the air-pump was set at 80 lbs. According to R54's most recent weight was 103 lbs. indicating the air-mattress was under-inflated. 46066 2. R18 is a [AGE] year old male admitted to the facility on [DATE] with diagnosis including but not limited to Chronic Respiratory Failure, Encephalopathy, Quadriplegia, and Muscle Weakness. R18's care plan dated 08/10/2023 reads in part, R18 has a potential for pressure ulcer development related to disease process, immobility, respiratory failure, and anxiety. Interventions: Provide specialty mattress (Low air loss mattress). On 09/23/24 at 11:51 AM Surveyor observed R18 laying in supine position on low air mattress in the static mode. On 09/25/24 at 10:25 AM Surveyor observed R18 laying in supine position on low air mattress in the static mode. 3. R41 is a [AGE] year old male admitted to the facility on [DATE] with diagnosis including but not limited to Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Site, Encephalopathy, Chronic Kidney Disease, Functional Quadriplegia, and Anoxic Brain Damage. R41's care plan dated 06/12/2023 reads in part, R41 has potential for pressure ulcer development. Disease process with diagnosis of, DM, Respiratory Failure, Trach status, Anemia, Anoxic brain damage, Depressive disorder, CKD, Immobility. Interventions: R41 Requires pressure relieving/reducing device on bed/chair. On 09/24/24 at 10:38 AM Surveyor observed R41 laying in supine position on low air mattress in the static mode. 4. R121 is [AGE] year old male admitted to the facility on [DATE] with diagnosis including but not limited to Spinal Stenosis, Acute Respiratory Failure, Muscle Weakness, Epilepsy, and Depression. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R121's care plan dated 05/21/2024 reads in part, R121 has potential/actual impairment to skin integrity r/t fragile skin, comorbidities. Interventions: The resident needs pressure relieving/reducing mattress, pillows, sheepskin padding etc. to protect the skin while in bed. On 09/22/24 11:51 AM Surveyor observed resident's mattress in static mode while resident was asleep in the bed. According to records, R121 has stage 4 sacral wound, acquired prior to facility admission and required a specialty air mattress to off-load pressure on his wound. 09/25/24 10:25 AM V4 (wound nurse) stated, They (residents with pressure ulcers) should be on alternating pressure. No fitted sheets, remove the static mode because if the patient is on bed it needs to be on alternating pressure because static pressure mode makes the bed firm and over-inflates the bed and does not alternate pressure for it to be effective. The weight of the patient corresponds to the settings on the mattress because if its under-inflated or over-inflated, it doesn't respond to wound healing. If its under-inflated, it makes the bed soft and if its over-inflated it makes the bed very hard and makes the patient uncomfortable. This all contributes to wound healing and if these things aren't correct, it defeats the purpose of a specialty air mattress. Air mattress user manual provided by V4 to surveyors reads in part, Effective pressure redistribution therapy, wound management and device selection should be based on the patient's specific condition and complete assessment of needs, recognizing that pressure prevention devices are only one component of a comprehensive pressure injury management program. Support surfaces are not substitutes for turning, reposition or functional weight shifts by care givers. Weight settings: Weight settings can be used to adjust the pressure of the inflated cells based on the patient's weight and comfort level. Static mode: Press the select turn button on the panel to none to set the system to static therapy mode. The system will remain in no rotation (or center position) at the constant desired patient comfort level. Rotation Mode: Turning mode can be selected from the panel to choose the appropriate turn position. Turning modes include combinations and adjustable position up to 40 degrees with left, right, both or none (static) directions.

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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** 40987 Based on observation, interview and record review, the facility failed to monitor and prevent a high risk cognitively impaired resident from sustaining a preventable fall, failed to provide fall preventative devices, failed to develop/implement a plan of care for residents at high risk for falls, and failed to educate staff on identifying and protecting residents from accidental falls. This failure affects 1 (R57) of 1 residents reviewed for falls in the sample of 28. R57 was admitted to the hospital with a left comminuted (multiple bone breaks) femur fracture with surgical intervention as a result of this failure. Findings include: R57 is a cognitively impaired resident with diagnoses including but not limited to End Stage Renal Disease, Major Depressive Disorder, Dependence on Renal Dialysis, Other Abnormalities of Gait and Mobility, Lack of Coordination, Long Term (Current) Use of Anticoagulants, Reduced Mobility, and Weakness. R57's MDS Minimum Data Set (Comprehensive Assessment) dated 05/24/24 documents a brief interview for mental status (BIMS) score of 4 out of 15. A score of 0-7 indicates severe cognitive impairment. All 3 consecutive MDS assessments dated 05/24/24, 02/27/24, and 12/06/23 maintain R57's cognitive decision making to be severely impaired with the latest MDS assessment showing a significant change post-fall incident. Four consecutive fall risk assessments dated 12/1/2023, 4/15/2024, 5/20/2024, and 7/17/20204 all assess R57 at High Risk for Falls. On 9/23/24 at 11:15 AM, R57 was observed in bed asleep. One fall mat on the floor next to the right side of the bed. No other fall precautions were in place. On 09/25/24 at 10:51 AM, interview with V16 Maintenance Technician regarding R57's fall on 07/17/2024. V16 said, I got a work order for the room. I knocked on the door and asked if I could come in. I was there for bed B by the bathroom because the TV wasn't working. When I saw R57 she was in bed A she was sitting in the middle of the bed facing the door. I came and went in the middle of both beds. I started to set up the TV remote for bed B. I heard a loud thud noise like something dropped. I turned my face and saw (R57) on the floor. I said just a minute to R57, and I went to the nurse's station. V8 RN was in the hall, and I said somebody in the room was on the floor. She went into the room first. I didn't go back into the room. As soon as I knew what happened V1 Administrator and V5 Restorative Nurse came and talked to me. They said I had to make a report and I wrote it down. This surveyor showed V16 Maintenance the written statement provided by V1 Administrator and asked if he saw her fall. V16 said, That's mine. I didn't see her fall; I saw the privacy curtain move after she fell . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 09/25/24 at 11 :24 AM, V8 RN inquired of R57's fall incident on 07/17/2024. V8 said, V16 Maintenance came to me I was in the hallway passing medication. He told me someone had fallen in the room. I went into the room and R57 was on the floor by the side of the bed. I told V16 Maintenance to call for help to get her off the floor. While I was assessing her, I asked her if she had pain. I checked her extremities and skin. She said she had pain on both thighs. She said the pain was about 3 out of 10. She was able to move her extremities at her baseline, able to move everything. I asked if she hit her head on the floor and she said no. I asked her how she fell . She said she was trying to get out of the bed. She didn't say where she was going. The other staff came in and helped me get her off the floor. V21 CNA, another restorative person, V18 RN, and I lifted R57 and put her back in bed. R57 didn't show any pain. R57 has confusion sometimes. They helped me put her back in bed and we turned her, and I checked her skin if she had any bruises. I asked her to move her arms and legs and she was able to move as much as she can. Surveyor asked to clarify how she assessed and interviewed R57 given her severe cognitive impairment, V8 said, I didn't ask her to show me where her pain was. I just checked her skin and asked her to move. I talked to V16 Maintenance, and he said he didn't actually see her fall, he just heard her fall. I called the V20 NP Nurse Practitioner on the phone about the pain she had, and she ordered an x-ray. V20 NP Nurse Practitioner was in the building. She said to give her Tylenol. We have a protocol for 72 hour neurological checks and follow up fall monitoring. I gave her Tylenol after the incident because she had an order. I went back in thirty minutes, and she wasn't having pain. R57 speaks English and I understood her clearly. She didn't have any changes to her condition. I called for an x-ray for her hips and pelvis, left femur and left elbow. I didn't say anything about R57's left side, it's just what the V20 NP ordered. I ordered the x-ray stat (immediately). They didn't say when they'd come. I work 7AM to 7PM. They didn't do the x-ray before I left so I gave report to the oncoming nurse. I said the x-ray hadn't been done yet. I didn't tell anyone else that the x-ray wasn't done yet. V8 was asked if she completed the fall event form for R57 and why certain areas were left blank. V8 said, Yes, I did it. Was R57 ambulatory? Why was the ambulatory status and extremities section left blank? V8 was asked, did you check her range of motion and position of her extremities? V8 RN said, No, she wasn't. She was a one person assist to a wheelchair. She could bear her weight and transfer to a wheelchair. I accidently left it blank; she didn't have any deformities. V8 was asked, was R57 a fall risk? How would you know if she was a fall risk? If so, what interventions were previously in place? V8 said, I'm not sure if she was. It would have been in her profile. This was the first time I worked with her. There's a folder on the unit with the fall risks. I'm not sure I checked. I could have checked her care plan, but I didn't. A nursing note written by V8 RN reads in part, On 7/17/24 at 11:30 AM, a staff member from maintenance notified NOD (nurse on duty) that resident was on the floor. Upon arrival in resident's room, NOD noted resident sitting on the side of the bed. Resident stated I was trying to sit on the side of the bed and lost my balance while trying to get up. Head to toe assessment done, no injury noted, able to move all extremities at baseline, VS (vital signs) taken and recorded, resident with complaint of pain on both thighs, Tylenol 650 mg PRN (as needed) administered. Resident denies hitting head at this time. V20 NP Nurse Practitioner notified with order for Xray of bilateral hip and pelvis, left femur, and left elbow order confirmed and carried out. Notified POA (Power of Attorney) via voicemail as cell phone wasn't picked up. Ongoing Neurological check and 72 hour post monitoring initiated. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R57's progress notes reflect the x-ray was not performed by the portable x-ray company until 07/18/24. On 09/25/24 at 12:29 PM, V21 CNA Certified Nurse Assistant said, R57 is alert and knows where she is and what she wants. I was in her room after she was done with her restorative. I warmed up her milk and set up her tray while she was in bed. She was eating and I went back to the nurse's station. V16 Maintenance came and told me someone was on the floor. When I went to the room V8 RN, another nurse and V16 Maintenance were in the room. R57 was sitting on the floor next to the bed. I asked her what happened. She's not confused. R57 said I thought I could walk by myself. V8 RN assessed her and R57 said she was fine and didn't hurt herself. The nurses and I helped lift her up and we put her sling underneath her. We hooked it up to the mechanical lift and placed her on the bed. She didn't show any pain. The nurses checked her body, we repositioned her. She was wearing a house dress. They didn't take her dress off, they just lifted it up. I just checked on her after that, she didn't say anything hurt. V21 CNA said, R57 wasn't a fall risk because she never tried to get up. If she was a fall risk, we'd have a low bed and use little mattresses on the floor both sides of the bed. She only had the low bed. How would you find out if R57 was a fall risk? V21 CNA said, The restorative nurse educates the nurses and aides. On 09/25/24 at 1:00 PM, two surveyors visited R57 and observed the resident laying in the bed. There was one fall mat beside the resident's bed and another that was folded up and leaning in the corner of the room not being utilized. A call light was wrapped multiple times around R57's side rail and with the call light button tucked under R57's pillow away from R57's reach. V8 (RN) was asked to affirm what the surveyor's observed. V8 said, The call light is under her so she can't reach it. She needs repositioning. She has a mat on the floor and the other is in the corner. It's supposed to be on the other side on the floor. There's a sign hanging on the wall, but I don't know what it means. V8 was asked if she has had any training on fall risk precautions and fall risk residents? V8 said, It was last month with V5 Restorative Nurse. The CNA or nurse should make sure the fall precautions are in place. I'll tell her CNA to put the other mat down and to give her the call light. V8 RN attempted to speak to R57 asking, How are you feeling? Do you know where you are? R57 did not respond. V8 said, She wasn't able to answer. V8 was asked if this a change in her mental status? V8 said, Yes, she usually answers. On 09/25/24 at 01:27 PM, interview with V18 RN regarding R57's fall incident from 07/17/24. V18 RN said, I didn't witness her fall, I was on the other end. One of the CNA's came and got me. I got to the room, and they were asking for help to transfer back to bed. She was sitting on the floor next to the bed on the right side. I helped them. They had a mechanical lift pad or sheet underneath her, and just helped them get her in the bed. We repositioned her and I left. R57 shook her head no when asked if in pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 09/25/24 at 01:33 PM, V5 Restorative Director was interviewed regarding R57's fall incident on 07/17/24. V5 said, I was aware she fell on Wednesday the 17th; V8 RN reported it to me. I wasn't there during the assessment. I saw her after when she was in bed just to look at her to see what interventions we could place. R57 was sleeping, she wasn't able to answer me. I talked to her between Thursday and Friday. I asked R57 before she went out and she told me she was sitting on the side of the bed and was trying to get up, that's what she said. She had x-rays ordered on Wednesday; we got the results on Thursday night close to midnight. It said signs of old fracture healed in the results. On Friday the nurse had the report in hand, and I called the V20 NP Nurse Practitioner. When I told her she said to send R57 out to the hospital. I called the family, her POA, and told him we received the x-rays, and he was grateful. When she went to the hospital I called to see if they were admitting her. I did the interdisciplinary note. She was a high fall risk. She scored a 10 or higher on all her fall risk assessments done upon admission, quarterly, and annual. V5 said, We do 50% or more of the effort so we put a gait belt on her and a walker and follow with a wheelchair for resting periods. V5 was asked, what interventions were in place when she fell ? V5 said, I would have to check, we didn't have the landing mats at that time. We only place interventions when there's a fall. This was her first fall with me. If anyone scores high, we don't place any interventions until they fall. She didn't have any interventions at that time. The only thing was to keep her bed in a low position. We do purposeful rounds, the four P's everyone does them. Position, check a resident. Potty, if they're soiled, clean them. Possessions, place items and call light within reach, before leaving ask if there's anything they need. I can't remember the last P. R57's fall was due to lack of coordination and weakness. V5 said, Yes, she was able to use it (call light). She was alert and oriented x 1 (person) to 2 (place) with bouts of confusion, but she's able to verbalize needs and follow simple instructions. V5 was asked, what are her current fall interventions? V5 said, She has landing mats bilaterally and while in bed. Regarding knowing if resident is a high fall risk, V5 said, We started training staff to use a cared file system, it's on the residents profile. It's new about a month ago. It would say high fall risk and if they have fallen it's shows what interventions are there. V5 said, Between me, nurses, CNAs, and RNAs (restorative nurse assistant). Once a resident falls and has interventions in place we tell them the interventions. I started the training of the card file on Tuesday the 24th. I have fall binders in the nurse's station, one per floor. At that time, this was the other way to know if they were a fall risk. They could also check the care plan. The card file system is in the electronic chart record. (continued on next page)

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Rivaya Care of Des Plaines	9300 Ballard Road Des Plaines, IL 60016

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 09/26/24 at 12:34 PM, interview with V20 NP Nurse Practitioner regarding R57's fall on 07/17/24. V20 NP said, Nursing staff called me on 7/17 the day of the fall, I'm not sure if I was in house. R57 is in bed most of the day, a dialysis patient. She is forgetful but could voice her needs and use her call light. Alert and oriented x 2 (to person and place) maybe. She was in the bed. She wasn't in any pain or distress. She said she was attempting to sit at the edge of the bed and slid off is what was told to me by the nurse. Nursing said staff found her sitting on the floor. My note is from 7/18/24. I did a full assessment. She was complaining of pain with movement of the left leg but appeared to be comfortable. She wasn't in any distress. There was no deformity from my clinical judgement. Sometimes a fracture can't be seen. She was in some pain. I ordered x-rays bilateral hip and pelvis, left femur and elbow. In this situation I ordered them stat, so it should be done as soon as possible. I ordered blood work to make sure nothing was underlying. After I saw the x-ray from (the x-ray company), I ordered R57 to be sent to the hospital for further evaluation. The x-ray doesn't say it's acute, it says healed or healing pubic fracture and Osteopenia. Due to this and her having a fall I ordered her to be sent for further evaluation. V20 was asked, were you informed the x-ray wasn't completed until 07/18/24? V20 NP said, I don't remember when the x-ray was done. I usually ask when I come in the next day. If not, I ask them to call the x-ray company. I don't remember if the nurse told me when it was done. It's been more difficult with this company. It's a common thing that a nurse should report that. When the x-ray company comes, they don't even tell the nurses when they are there and when it (the x-ray) was done. It's expected to be done as soon as possible the same day. R57 has an order for Tylenol 650mg by mouth every 6 hours as needed. I can't remember if V8 RN told me about how well she tolerated it. The nurses usually document the pain assessment and let me know if any additional orders are needed. Review of R57's POS (Physician Order Sheet) states in part she was prescribed Heparin 5,000 units/ml (milliliter) injectable solution. Inject 1ml (milliliter) into the skin every 12 hours. Heparin is in a class of anticoagulant medications used to prevent and treat blood clots. It works by decreasing the clotting ability of the blood (blood thinner). Falls can cause bone fractures which can be more serious for patients taking blood thinners due to the risk of severe bleeding. R57's 05/20/2024 care plan indicates R57 is at risk for falls related to vomiting, generalized weakness and multiple chronic disease conditions. Dx: HTN (Hypertension), COPD (Chronic Obstructive Pulmonary Disease), CKD-4 (chronic kidney disease), Anemia diagnosis of End Stage Renal Disease, COPD, Anemia, muscle weakness, difficulty walking, reduced mobility. Interventions: educate resident to use call light for assistance. Encourage resident to ask staff to help her put her sweater on. Keep furniture in locked position. Keep needed items, water, etc. in reach. Maintain a clear pathway, free of obstacles. Avoid repositioning furniture. Provide visual prompts to ask for help. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes as possible. Educate resident/family/caregivers/interdisciplinary team as to causes. Educate R57/family/caregivers about safety reminders and what to do if a fall occurs. R57 Needs activities that minimize the potential for falls while providing diversion and distraction. Encourage R57 to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Ensure that R57 is wearing appropriate footwear when mobilizing in wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R57 is on Anticoagulant therapy (Heparin injection) for clot prevention. R57 is at risk for bleeding and complications. Interventions: Daily skin inspection. Report abnormalities to the nurse. R57/family/caregiver teaching to include the following: take/give medication at the same time each day, use soft toothbrush, use electric razor, avoid activities that could result in injury, take precautions to avoid falls, signs/symptoms of bleeding, avoid foods high in Vitamin K. These include greens such as spinach and turnips, asparagus, broccoli, cabbage, brussels sprouts, milk, and cheese. Labs as ordered. Report abnormal lab results to the MD. Monitor/document/report to MD (medical doctor) PRN (as needed) signs/ symptoms of anticoagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, , diarrhea, muscle joint pain, lethargy, bruising , blurred vision, SOB (shortness of breath), loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. Review medication list for adverse interactions. R57'S 05/24/24 MDS Minimum Data Set (Comprehensive Assessment) Section GG Mobility states in part C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. The portable x-ray company's date of service for R57 states in part 07/18/2024 x-ray of the pelvis and bilateral hips, five views. Impression: 1. Impacted left subcapital femoral neck fracture deformity, of unknown age. 2. Healed or healing left inferior pubic ramus fracture. The portable x-ray company's date of service for R57 states in part 07/18/2024 x-ray of the left femur, AP (anterior to posterior) and lateral. Impression: 1. Subcapital left femoral neck fracture deformity, of unknown age. 2. Osteopenia. R57 was hospitalized on [DATE] through 07/31/2024 with a diagnosis of closed fracture of the left hip. The physical exam for musculoskeletal indicates left hip restriction of range of motion due to pain. The 07/19/2024 hospital (CT) Computed Tomography Scan of the pelvis without contrast indicates final result 1. Comminuted (a bone breaks into more than two pieces), mild to moderately displaced left sacral ala fracture, extending to the left sacroiliac joint. Additional comminuted. mildly displaced fracture of the left posterior superior iliac spine, also extending to the sacroiliac joint. Suspected mild left sacroiliac joint diastases. 2. Comminuted, mildly displaced fractures of both superior and inferior pubic rami. Additional mildly displaced fractures of both acetabular and anterior columns. 3. Mildly displaced and impacted fracture of the left femoral neck, possibly Basi-cervical. 4. Focal angulation of the right femoral head-neck cortex may represent a nondisplaced fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The assessment and plan indicate left hip fracture: patient has been evaluated by orthopedics plan for surgical intervention today. The preoperative diagnosis states in part 1. Left displaced femoral neck fracture. On 07/23/24 R57 had Left Hip Arthroplasty (a surgery to restore the function of a joint. The joint is replaced, remodeled, or realigned.) The 02/13/24 Fall Prevention and Management Policy states in part: Policy Statement: The facility is committed to its duty of care to residents and patients in reducing risk, the number and consequences of falls including those resulting in harm and ensuring that a safe patient environment is maintained. Procedures: Fall Risk Screening a. Residents and patients will be screened to determine fall risk. b. Fall risk screening will be used on admission, readmission to the facility, following a fall, following a change in status, and quarterly. c. High risk residents will receive interventions as appropriate to risk factors. Fall Interventions a. Fall precautions will be implemented for residents as appropriate. b. The IDT (interdisciplinary team) will discuss interventions that may be added to the resident's care plan. c. Fall interventions may include, but not be limited to: assess the need for an assistive device for mobility and locomotion. Meaningful activities are encouraged. Keep hearing aids, glasses, dentures with the resident. Pharmacy may review medications for any potential side effects/drug interactions. Physical/Occupational evaluation as appropriate. Assess needs for toileting or incontinence care. Restorative may evaluate programs such as ambulation, transfers, and bed mobility. Room change near the nurses station if available. Development of Plan of Care a. An interim or basic care plan will be initiated for all new admissions or readmissions. b. A comprehensive falls care plan will be developed. c. A review of the current care plan will be conducted after the fall with the IDT.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 40987 Based on observation, interview and record review the facility failed to recognize, evaluate and manage pain for a 1 (R57) resident with severe cognitive impairment of 3 residents reviewed for pain management in the sample of 28 residents. This failure affected R57 receiving inadequate pain medication after an unwitnessed fall, and failure to thoroughly assess and monitor for further pain for over 48 hours until being emergently sent to the hospital for treatment of a femur fracture requiring surgical intervention. Findings include: R57 is a cognitively impaired resident with diagnoses including but not limited to End Stage Renal Disease, Major Depressive Disorder, Dependence on Renal Dialysis, Other Abnormalities of Gait and Mobility, Lack of Coordination, Long Term (Current) Use of Anticoagulants, Reduced Mobility, and Weakness On 09/25/24 at 02:25 PM, Surveyor inquired with V1 Administrator about R57's fall incident and report to IDPH Illinois Department of Public Health. V1 said, R57 fell during the daytime, and she complained of pain. X-ray was ordered, technician came the next day, and the results came at midnight. She fell on a Wednesday and the results came between Thursday night and Friday morning. Based on the results of the x-ray relayed to the V20 NP R57 was transferred to the hospital. I found out from V5 Restorative Nurse on Monday or Tuesday that R57 was going to have surgery for a hip fracture. R57 was sent to the hospital for further evaluation. It was a recommended procedure for R57 to have surgery. This is a fall with a serious injury. The hospital conducted its own evaluation and confirmed the fracture, that's why she had the surgery. A nursing note written by V8 RN reads in part, On 7/17/24 at 11:30 AM, a staff member from maintenance notified NOD (nurse on duty) that resident was on the floor. Upon arrival in resident's room, NOD noted resident sitting on the side of the bed. Resident stated, I was trying to sit on the side of the bed and lost my balance while trying to get up. Head to toe assessment done, no injury noted, able to move all extremities at baseline, VS (vital signs) taken and recorded, resident with complaint of pain on both thighs, Tylenol 650 mg PRN (as needed) administered. Resident denies hitting head at this time. V20 NP Nurse Practitioner notified with order for Xray of bilateral hip and pelvis, left femur, and left elbow order confirmed and carried out. Ongoing Neurological check and 72 hour post monitoring initiated. R57's progress notes reflect the x-ray was not performed by the portable x-ray company until 07/18/24 a day after R57 sustained a mechanical fall. There were also no pain assessments conducted or pain medications during the time period based on the medical records provided to surveyor. R57's MDS Minimum Data Set (Comprehensive Assessment) dated 05/24/24 documents a brief interview for mental status score of 4 out of 15. A score of 0-7 indicates severe cognitive impairment. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Surveyor asked to clarify how she (V8-RN) assessed and interviewed R57 given her severe cognitive impairment. V8 said, I didn't ask her to show me where her pain was. I just checked her skin and asked her to move. I talked to V16 (maintenance man), and he said he didn't actually see her fall, he just heard her fall. I called the V20 NP Nurse Practitioner on the phone about the pain she had, and she ordered an x-ray. V20 NP Nurse Practitioner was in the building. She said just to give her Tylenol. We have a protocol for 72 hour neurological checks and follow up fall monitoring. I gave her Tylenol after the incident because she had an order. I went back in thirty minutes, and she wasn't having pain. R57 speaks English and I understood her clearly. She didn't have any changes to her condition. I called for an x-ray for her hips and pelvis, left femur and left elbow. I didn't say anything about R57's left side, it's just what the V20 NP ordered. I ordered the x-ray stat (immediately). They didn't say when they'd come. I work 7 AM to 7 PM. They didn't do the x-ray before I left so I gave report to the oncoming nurse. I said the x-ray hadn't been done yet. I didn't tell anyone else that the x-ray wasn't done yet. Surveyor asked if she provided any other pain medications other than the one dose of Tylenol, V8 indicated that she provided only one time. The July MAR (Medication Administration Record) showed on July 17th, 2024 on the day of the fall incident, R57 was administered two tablets of regular strength Tylenol for mild pain by V8 (RN). This same nurse assessed a severely cognitively impaired resident with a pain level of 3 for mild pain after an unwitnessed mechanical fall to the floor sustained by R57. There were no additional pain medications administered to R57 from the 1 dose throughout her discharge to the hospital on July 19, 2024. Further review of the July medication administration records showed no other pain assessments were conducted for the entire month of July 2024. On 7/17/24, there is one pain evaluation written by V8 post fall incident with incomplete information and assessment of R57's pain and interventions for the pain. V8 left blank on the pain assessment form the sight, onset of pain or duration of the residents pain. R57's quality of pain was an ache. Numerous blanks of the assessment including any non-verbal indicators of pain or pain exacerbating factors for a resident with severe cognitive impairment. There were no non-pharmacological interventions provided. V8 indicated that Tylenol 650 mg should have been provided every 4 hours and as needed but left blank whether the resident had any side effects from the pain medication or if there were any signs of sedation, nausea, constipation, indigestion or diarrhea or whether the resident was receiving any medications to alleviate side effects which again was left blank. On 09/26/24 at 12:34 PM, V20 NP Nurse Practitioner V20 NP said, Nursing staff called me on 7/17 the day of the fall, I'm not sure if I was in house. R57 is in bed most of the day, a dialysis patient. She is forgetful but could voice her needs and use her call light. Alert and oriented x 2 (to person and place) maybe. She was in the bed. Per V8, she wasn't in any pain or distress. The nurse said that the resident was attempting to sit at the edge of the bed and slid off is what was told to me by the nurse. Nursing said staff found her sitting on the floor. My note is from 7/18/24. I did a full assessment. She was complaining of pain with movement of the left leg but appeared to be comfortable. She wasn't in any distress. There was no deformity from my clinical judgement. Sometimes a fracture can't be seen. She was in some pain. I ordered x-rays bilateral hip and pelvis, left femur and elbow. In this situation I ordered them stat, so it should be done as soon as possible. I ordered blood work to make sure nothing was underlying. After I saw the x-ray from (the x-ray company), I ordered R57 to be sent to the hospital for further evaluation. The x-ray doesn't say it's acute, it says healed or healing pubic fracture and Osteopenia. Due to this and her having a fall I ordered her to be sent for further evaluation. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	V20 NP said, I don't remember when the x-ray was done. I usually ask when I come in the next day. If not, I ask them to call the x-ray company. I don't remember if the nurse told me when it was done. It's been more difficult with this company. It's a common thing that a nurse should report that. When the x-ray company comes, they don't even tell the nurses when they are there and when it (the x-ray) was done. It's expected to be done as soon as possible the same day. R57 has an order for Tylenol 650 mg by mouth every 6 hours as needed. I can't remember if V8 RN told me about how well she tolerated it. The nurses usually document the pain assessment and let me know if any additional orders are needed. Facility's policy dated 1/01/2021 titled Pain Management reads in part, The facility will provide adequate pain assessment and management to that residents attain or maintain the highest practicable physical mental, and psychosocial well-being. Procedure: Evaluate the resident for pain upon admission, during periodic scheduled assessments, and with change in condition or status (after a fall, etc.). Behavior signs and symptoms that may suggest the presence of pain include: change in gait, loss of function, decline in activity, resisting care, bracing, guarding or rubbing, fidgeting, facial expressions of grimacing, frowning, fear, grinding of teeth; change in behavior: depressed mood, decreased participation in usual activities of daily living, loss of appetite, sleeping poorly, sighing, groaning, crying, breathing heavily. Assessment and evaluation: Asking the patient to rate the intensity of his/her pain using a numerical scale or a verbal or visual descriptor that is appropriate and preferred by the resident. Review of the resident's diagnosis or conditions that may be causing or contributing to pain. Identifying key characteristics of the pain, obtaining descriptors of the pain, determining factors that make the pain better or worse, identifying recent exacerbations of pain, impact of pain on quality of life. Current prescribed pain medications, dosage and frequency. Non-pharmacological pain management interventions include adjusting room temperature, smoothing linens, turning and repositioning to a comfortable position.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46066 Based on interview and record review, the facility failed to notify physician of abnormal results for urinalysis in a timely manner for 1 (R125) of 3 resident reviewed for laboratory services in the sample of 43. Findings include: R125 is a [AGE] year old male, admitted to the facility on [DATE] with diagnosis including but not limited to Hemiplegia, Heart Failure, Retention of Urine, and Urinary Tract Infection. On 09/23/24 at 12:29 PM Surveyor observed R125's urinary bag and urinary catheter tube. Urine noticed to be dark yellow and slightly cloudy. On 09/25/24 at 12:09 PM Surveyor interviewed V6 (Registered Nurse) who stated the following, I work with R125 today. We completed urinalysis with urine cultures couple of weeks ago due to R125 complaining of burning upon urination. I got the order, collected the urine sample, and received an order for an antibiotic based on the abnormal urine results. If there is a pending lab order, nurses check on an ongoing manner throughout their shift. If the lab result is critical, we get a call from the lab. It takes up to 24 hours for urinalysis to come back and about 72 hours for a final urine culture. I found out in the morning hand off report that R125 has urine culture pending. I didn't check R125's urine results today. I will do it right now. V6 (RN) checked R125's urine results in the surveyor presence and said, Based on what I see, R125's urine result is abnormal, I have to notify the nurse practitioner. On 09/25/24 at 01:04 PM Surveyor interviewed V18 (Registered Nurse) who stated the following, I worked with R125 yesterday (09/24/2024). I was not aware that that R125 had pending urinalysis yesterday, the previous nurse did not mention it to me in the hand off report. Usually, when I receive an order for urinalysis, I collect the urine sample. Once the sample is collected, its placed in the specimen fridge and lab gets notified that the specimen is ready for a pickup. Usually, specimens get picked up in the morning time. If the lab sends results back to the facility, those can be checked in the electronic medical record, under the result tab. There is no specific time to check, but most of the results come in the afternoon, and I check 3 to 4 times a shift. I checked results right before I left yesterday, around 6p, and I didn't see any results for R125. On 09/25/24 at 11:06 AM Surveyor noticed R125's Lab Result Report for Urinalysis read, Collection Date: 09/24/2024 05:00 (AM), Received Date: 09/24/2024 01:08 PM, Reported Date: 09/24/2024 03:23 PM. Review status: Reviewed. On 09/25/2024 at 12:41 PM Surveyor noticed R125's Lab Result Report for Urinalysis read, Collection Date: 09/24/2024 05:00 (AM), Received Date: 09/24/2024 01:08 PM, Reported Date: 09/25/2024 12:22 PM. Review Status: To Be Reviewed. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noticed discrepancy in Reported Date and Review Status indicating that R125's abnormal urinalysis results were reviewed on 09/24/2024 at 03:23 PM and not reported to the physician for further treatment recommendation. No progress notes present in R125's electronic medical record pertaining to abnormal urinalysis results. On 09/26/2024 at 12:22 PM Surveyor interviewed V2 (Director of Nursing) who stated the following, Collection date on the laboratory report is when the specimen is collected, receive date is when the lab receives the specimen, and report date is when the lab result is being reported back to the facility. If you open laboratory report and review it, the report date changes into most recent date and the initial date of reported date gets overwritten. When a nurse receives an abnormal lab, it goes automatically into resident's EMR, and the nurse should notify the nurse practitioner or physician of an abnormal result. If there is an order, the nurse should carry it out and make a progress note in regard to the lab result and associated interventions. The abnormal result should be reported to the physician as soon as possible. The nurse should be checking throughout the shift for lab results. The facility Policy: Diagnostic Testing Results dated 02/02/2024 reads in part, To provide direction for the staff on reporting diagnostic ad radiology report. If the results are abnormal, the nurse will communicate the results based on the severity of the results and physician request.