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COVENANT HLTH CR CTR-BATAVIA	831 NORTH BATAVIA AVENUE BATAVIA, IL 60510

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F 498	Continued From page 26 facility administrative staff thoroughly investigated these incidents and/or developed the direct care staff's skills in an attempt to decrease the frequency of injuries. On 6/24/07 at 8:10 p.m. E10 (CNA) and E25 (CNA) were observed transferring R86 from her wheel chair to the toilet. R86 was observed not to be able to push herself up out of her wheel chair and was dependent on staff to lift her out of the wheel chair. E10 and E25 were both noted with gait belts around their waists. E10 and E25 grabbed R86 under her arms and grabbed the back of R86's pants on either side, stood R86 up, turned R86 around and sat her on the toilet. Neither of the CNA's utilized the gait belt to transfer R86 to the toilet. On 6/25/07 at 3:30 pm E10 (CNA) was observed transferring R94 to the bathroom. E10 had a gait belt around her own waist but did not use the gait belt to transfer R 94. E10 transferred R 94 by holding her under her left arm and pulling R 94 up holding on to the back of her pants. E10 stated "I don't use the gait belt to transfer R 94. Review of the facility's policy on gait belt transfers showed documentation that "A gait belt is used by a nursing staff member in order to safely transfer and/or ambulate a resident with a mobility problem. The gait belt policy also shows documentation for reason for use is for "safety during ambulating and/or transfer."	F 498		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a)c)2) 300.1210a)	F9999		

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F9999	Continued From page 27 300.1210b)4)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. c) These written policies shall include, at a minimum the following provisions: 2) Resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic service (including laboratory and x-ray). Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised	F9999		

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F9999	Continued From page 28 nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include at a minimum the following procedures: b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 4) Personal care shall be provided on a 24-hour, seven day a week basis. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to monitor/supervise, update and implement interventions to prevent residents from sustaining fractures, bruises, head injuries, neck strains, and skin tears during mechanical lift transfers and falls. This is for 8 residents inside the sample of 20 (R1, R11, R25, R20, R21, R17, R16, and R3) and seven residents outside of the sample (R30, R61, R68, R106, R34, R105, and R28). Three residents sustained fractures (R1, R25 and R20), one resident (R30) received repeated bruises to his elbows and seven residents (R61, R68, R21, R106, R11, R34 and R105) received bruises/skin tears while direct care staff were transferring these residents via mechanical lifts. One resident (R28) sustained a hip fracture after	F9999		

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F9999	Continued From page 29 a fall on 7/9/06, and an intercranial hemorrhage after a fall while direct care was ambulating R28 from his bed to the bath room on 1/26/07. One resident (R21) sustained several /bruises skin tears of unknown origin. One resident (R17) with multiple falls sustained a fracture of pelvis, a fracture of left orbit, skin tears and abrasions to extremities. One resident (R16) sustained bruises, hematomas and abrasions after experiencing multiple falls at the facility. One resident (R3) had continuous pain after experiencing multiple falls. Findings include: 1. A review of the facility's incident/accidents reports from June 2006 through June 2007, identified 15 incidents (with 11 residents) where residents were injured while facility staff were transferring these residents via mechanical lifts/stands. Three residents (R1, R25, and R20) received fractures while direct care staff were transferring them via mechanical lifts/stands; One resident (R30) received bruises to his elbow three times while direct care staff were transferring him via mechanical lifts/stand through door ways and seven residents (R61, R68, R21, R106, R11, R34 and R105) received bruises/skin tears while direct care staff were transferring these residents via mechanical lifts/stands. R25 was admitted to the facility on 5/24/04. During a review of the facility's incidents on	F9999		

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F9999	Continued From page 30 6/25/07, it was noted that R25 had three incidents (6/15/06, 9/9/06 and 11/23/06) while facility staff were transferring R25 with mechanical lifts. A review of the facility's progress notes and the facility's incident report dated for 9/9/06 at 11:15 AM, read "direct care staff reported while transferring R25 to the bathroom with the mechanical standing lift (EZ stand), R25's leg gave out. R25 lowered to the floor by two direct care staff E6 and E9 (CNA's-Certified Nurses Aides). No injuries noted." At 4:00 PM on the same date, "R25 complained of increased pain to her right leg, hip and pelvis. R25 crying out and guarding leg when moved. X-ray ordered. At 4:45 PM, X-ray taken, at 9:00 PM facility received information that R25 had an "impacted right femoral neck fracture." R25 admitted to local community hospital 9/10/06 at 12:15 PM. A review of the facility's fall investigation report dated for 9/11/06 noted "R25 into bathroom with EZ stand- legs tipped side ways-direct care staff E6 called another direct care staff E9-R25 lowered to floor in bathroom. Direct care staff reported legs wouldn't fit up to knee pads properly." A review of the community hospital report dated for 9/10/06 read "R25's next of kin reported that R25 had not been ambulatory for the last two years and is strictly bed to wheel chair transfers. R25 admitted for evaluation with a diagnosis of right hip fracture." A review of R1's admission sheet found that R1 was admitted to the facility on 3/1/03. A review of the facility's Minimum Data Assessment dated for 11/16/06 and 5/17/07 found R1 to be assessed as dependent on staff for transfers and mobility. During an interview with R1 on 6/24 and 6/26/07,	F9999		

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F9999	Continued From page 31 R1 stated that she had been wheelchair dependent since birth. R1 stated that "it was a freak accident. The staff did not put the strap on correctly." A review of the facility's incident report dated for 2/7/07 "the direct care staff E8 (CNA) reports transferring R1 with EZ stand-strap on left side popped out-R1 leaning , did not fall-lowered to floor. R1 complained of pain to right knee." X-ray done to right knee on 2/8/07 with distal metadiaphyseal fracture with mild impaction diagnosis. A review of R20's admission sheet found that R20 was admitted to the facility on 11/19/97. A review of the facility's progress notes dated for 6/5/06 at 8:30 AM read "direct care staff E12 (CNA) reports she lowered R20 to the floor in the bathing room. No injuries noted." A review of the facility's Incident Report dated for 6/5/06 found "direct care staff E12 reported the lip of the lift chair caught on the side of the tub and started to tip over." At 5:00 PM, R20 complained of discomfort to the right groin area. X-ray ordered. On 6/6/06 at 8:30 AM, R20 was transferred to community hospital for evaluation. At 1:30 PM facility received a call that R20 was admitted to the hospital with a diagnosis of right hip fracture. During an interview with Z2 on 6/26/06 at 7:00 PM, Z2 stated that "R20 could do more for self before she had the fracture. The direct care staff did not put the chair belt on. When the lift hit the edge of the tub, R20 just slid out of the chair." During a review of the facility's incident reports on 6/25/07, it was noted that R30 had three incidents while a direct care staff E6 was transferring him out of the bathroom via mechanical stand. The incident report dated for 11/3/06 at 7:30 am read "direct care staff E15	F9999		

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F9999	Continued From page 32 (CNA) reported while transferring R30 with EZ stand to bathroom, R30 hit his right elbow on doorway to the bathroom. Skin tear cleansed with normal saline. Steri strips applied and covered with Telfa." The incident report dated for 3/6/07 at 7:30 AM read "R30 was on EZ stand coming out of bathroom elbow hit side of door. R30 was quoted to say 'that woman is crazy.' It was noted that R30 sustained a 2cm skin tear to right elbow." The incident report dated for 4/25/07 at 8:30 AM read "the direct care staff (E6) reports while transferring R30 into the bathroom with EZ stand, R30 bumped right elbow on doorway. R30 received skin tear. 2cm x 2cm. It was noted that this resident (R30) received skin tears to the right elbow while direct care staff was transferring him via mechanical stand either out or into the bathroom. There was no information found that the facility administrative staff thoroughly investigated these incidents to prevent reoccurrence. During an interview with E6 on 6/26/07, E6 stated that she never received any additional inservices or instructions after these incidents. E6 also stated "I was not looking at him when he bumped his elbow." Other examples of resident's injuries are; On 2/12/07 at 10:00 PM, the facility's direct care staff (E17-CNA) was using the facility's EZ stand, R61 sustained a 1cm skin tear. On 4/19/07 at 7:00 AM, the facility's direct care staff (E19-CNA) was using the facility's EZ stand, R68 sustained a 1 x 0.8 cm skin tear to left cheek. On 6/28/06 at 6:00 PM the facility's direct care staff (E16-CNA) was using the facility's EZ stand, R106 sustained a 4 x 2 cm skin tear to left leg. On 6/14/07 at 8:15 AM the facility's direct care	F9999		

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F9999	Continued From page 33 staff (E7-CNA) was using the facility's EZ stand, R11 sustained a 1.5 x 0.5 cm skin tear to the right forearm. On 3/29/07 at 8:30 AM, the facility's direct care staff (E20 and E21 CNA's) was using the facility's EZ stand, R34 sustained a bruise to her right foot. On 9/24/06 at 2:00 PM, the facility's direct care staff (E18-CNA) was using the facility's EZ stand, R105 sustained a 1cm skin tear to the right elbow. During an interview with E2 6/27/07, E2 presented documentation of two inservices that were presented to staff on EZ stand/lift. One was given in May of 2006 and the other was given in October of 2006. A review of the facility's competency evaluation check list found that the demonstrated competency evaluation is signed off by another direct care staff. There was no other information found that indicated that the facility administrative staff thoroughly investigated these incidents and developed the direct care staff's skills in an attempt to decrease the frequency of injuries. During an interview with E2 6/27/07, E2 presented documentation of two inservices that were presented to staff on EZ stand/lift. One was given in May of 2006 and the other was given in October of 2006. A review of the facility's competency evaluation check list found that the demonstrated competency evaluation is signed off by another direct care staff. There were no other information found that indicated that the facility administrative staff thoroughly investigated these incidents and developed the direct care staff's skills in an attempt to decrease the frequency of injuries.	F9999		

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F9999	Continued From page 34 2. Review of the facility's incident report dated 7/9/06 at 6:15 am, R28 was observed laying on his left side on the floor next to the television. Nursing notes dated 7/9/07 at 6:15 AM document, "Observed resident (R28) laying on floor on left side in his room. Denies pain/injury or hitting his head, no injury noted. Assisted with two CNA's from wheelchair to bed. Resident (R28) had unclipped and removed his bed alarm and did not use call light, R 28 stated 'I fell.'" Incident report dated 7/24/06 at 11:00 AM documents "Resident (R28) verbalized pain to left hip area with movement when to exercise. Noted resident with edema to left mid thigh and lower extremity." R28 was transferred to local emergency room, x-ray was done showing a left femoral neck fracture. Review of the incident report dated 1/26/07 at 9:30 am CNA (E 5) documents, "R28 lying on floor supine with legs extended toward door, head slightly under bed. E5 stated resident stumbling backwards then fell. R 28 sustained a 0.1 cm. skin tear to forehead, hematoma (bruising to the back of his head)." Incident report's conclusion dated 1/29/07 at 2:10 PM by E3 (Restorative Nurse) documents "E5 was taking him to the bathroom when she opened bathroom door there was old roommates wheelchair in there. She reported she let go of R 28 to pull out wheelchair when he began to upright reel back quite a few steps. He began to fall when she grabbed tail of gait belt but was unable to stop fall." Review of the nursing notes dated 1/26/07 at 9: 30 AM showed resident was ambulating in room	F9999		

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F9999	Continued From page 35 to bathroom with E5 using walker and gait belt. R28 lost his balance and stumbled backwards and fell, bumped back of head on floor. R28 sustained a 5 X 5 cm. hematoma and bruising to back of head, ice applied. R28 also sustained a 0.1 cm. skin tear to forehead. The site was cleansed and steristrips applied. Nursing note dated 1/26/07 at 2:30 pm shows R 28 up to meal in wheelchair, mechanical standing lift used for transfers. Tylenol given for headache. On 1/27/07 at 2:00 pm R28 complaining of blurred vision, dizziness and headache. Transferred to the local hospital for evaluation. Review of the hospital reports dated 1/27/07 documents, "The patient is an 84 year old white male residing at a nursing home who has recurrent falls over the past several months who apparently fell yesterday striking the front of his head. Today he complains of headache, dizziness and blurring of vision. CT scan showed two new small intracranial hemorrhages." Review of the facility's monthly summary dated 12/06 by E13 (RN) for R28 documents: Transfers with mechanical standing lift. Care plan dated 8/10/06 shows to assist resident with all transfers-one to one with gait belt/mechanical standing lift if resident is unsteady. Review of R28's physical therapy evaluation dated 1/31/07 shows R28 has a very shuffley gait; unsteady. On 5/3/07 care plan reviewed after head injury-no new interventions or approaches were discussed or developed. Minimum Data Set (MDS) dated 8/4/07 shows R 28 needs extensive assist during transfers. R28's fall assessment documents he is high risk for falls. Interview with E2 (DON) on 6/25/07 at 11:00 am, E2 said R28 fell early in July. He never fell again	F9999		

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F9999	Continued From page 36 that we know of, so we thought the hip fracture on 7/26/06 was related to the fall in the early part of July. We did neuro checks when he fell in January after his head injury and he did sustain a head injury and was taken to the hospital the next day. He does have an unsteady gait. 3. Interview with Z3 on 6/24/07 at 6:30 pm stated "I come everyday-morning, noon, or evening and no matter what time I come, I find R21 sitting in her wheelchair without the call light. It takes the aids a long time to answer, especially when they go on break. They bump her arms all the time in the doorways when they transfer her. I am disgusted with the aids. A review of R21's nursing notes shows the following incidents: 4/17/07-R21's husband and daughter found a greenish/yellowish bruise along R 21's lateral left shin (18cm. X 7 cm.) with 2 dark scabs 1 cm x 1cm in upper outer aspect of bruise-unknown how injury occurred. 4/27/07-skin tear to right knee, 0.5 cm in diameter abrasion-unknown how injury occurred. 5/7/07-E14 (CNA) was assisting R21 out of the bathroom using the mechanical mechanical lift and bumped her arms on the doorway sustaining a 1.5cm. X 1 cm. skin tear. 6/3/07-observed with bruise and scratches on left upper arm-unsure how injury occurred. 6/5/07-skin abrasion 3cm x 1 cm to right arm, rectangular shaped, small resolving bruise noted, steristrips and dressing-unknown how injury occurred. 5/30/07-noted with bruise to right elbow (2cm. X 2cm.) with small skin tear (0.5 cm X 0.5 cm) -unknown how injury occurred. 6/22/07-skin tear 1.5 cm abrasion to left shin and	F9999		

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F9999	Continued From page 37 5 cm faint blue bruise to left shin- unknown how injury occurred. Care plan update 6/22/07 states cause may have been due to transfer with mechanical standing lift. Review of R21's care plan dated 8/2/06 documents R21 requires total care in the areas of transferring (using mechanical standing lift), toileting, mobility (wheelchair), turning and repositioning. Care plan dated 6/18/07 documents to wear long, skin sleeves at all times. Care plan update on 5/30/07 documents R21 refuses to wear skin sleeves, wears long sleeves. Observations on 6/24/07, 6/25/07, 6/26/07 revealed that R21 was not wearing skin sleeves or shirts with long sleeves. R21's fall assessment documents she is at high risk for falls. During the daily status on 6/26/07, E2 (DON) stated, "R21 refuses to wear the skin sleeves, she is frail and uses the mechanical standing lift for all transfers. I e-mailed all the supervisors and told them to inservice the staff about transfers. No, I don't know if they did the inservice." On 6/27/07 surveyor observed R21 at the dining room table with skin sleeves on. Review of R21's weekly skin checklist dated 4/2/07 through 5/28/07 documents on 4/2/07 that R21 refused a skin check. Documentation on the skin check dated 5/28/07 shows skin was ok. No other assessments were documented. 4. Review of R17's admission face sheet showed that R17 is a 95 year old female admitted to the facility on 10/06/04. Observation of R17 on 6/24, 6/25 and 6/26/07 showed R17 to be alert but confused at times.	F9999		

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F9999	Continued From page 38 Review of R17's incident reports from 6/06/06 to 5/23/07 showed that R17 had nine incidents of falls. Of these nine incidents, R17 sustained injuries with six of the incidents. R17 sustained two fractures with two of the incidents and sustained skin tears and abrasions with four of the incidents. Interview with E8 (CNA) on 6/26/07 at 11:15 a.m. noted E8 to say, "R17 is confused at times, that's when she falls." Review of the two incidents with fractures showed with the first incident on 7/19/06, R17 was found laying on the floor in the hallway. R17 was noted to say, "My right hip hurts, I heard something snap." Incident documentation showed that R17 was wearing shoes but did not have her walker. Fall investigation documentation addressing mobility/alarm showed that R17 was only wearing an electronic monitoring device, not a monitoring device to help prevent falls. Review of the second incident with R17 sustaining a left orbital fracture dated 12/30/06 showed that R17 was leaving an activity from the dining room and fell forward "slamming head into table bottom." Telephone interview with E1 (Administrator) on 7/05/07 at 11:25 a.m. disclosed that R17 was left unsupervised for approximately one minute by E16 (Activity Assistant) and was found laying under a table upon E16's return to the activity/dining room. Further incident documentation showed that R17 had sustained an "open head wound, was not arousable, and was not moving." 911 was called and R17 was sent to a nearby hospital with diagnosis of left orbital fracture. Nursing documentation upon R17's return to the facility showed that R17 also had a bruise to the right	F9999		

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F9999	Continued From page 39	F9999		

neck and facial areas. The fall investigation for this injury addressing mobility alarm was blank showing no documentation that R17 had a mobility alarm in place to alert staff of R17's movement/mobility.

Other incidents noted where R17 sustained injuries with falls included:
06/06/06-Slid out of chair. Right knee abrasion. Right elbow skin tear.
11/25/06-Laying on floor near door to room. Hit head. Bump to right forehead. Skin tear to right forearm. To ER for CT scan.
03/17/07-Fell. Hips and legs tangled in sheets. 1 cm abrasion to left leg.
05/04/07-Fell on floor. Hit head on left side. Redness to left parietal area.

Review of all of the incidents in which R17 sustained injuries showed that none of the fall investigations showed that R17 was wearing a mobility alarm to alert staff of R17's mobility to help prevent R17 from falling. Review of R17's plan of care for falls showed that a bed/chair alarm was not added as an approach to prevent falls until 2/15/07.

Interviews with E1 (Administrator) and E2 (Director of Nurses) addressing R17's multiple falls noted both to say that R17 takes off her alarm and falls. No other interventions were noted to address additional monitoring/supervision of R17 to prevent further falls and injuries.

5. R16 was initially admitted to the facility 5/11/06 after sustaining a fall that caused a right side sub-dural hematoma and resulted in R16 having left side hemiplegia, cognitive deficits and

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F9999	Continued From page 40 left side neglect. R16's 5/06 hospital discharge transfer form and 4/06 hospital history and physical form state that R16 is on safety/fall precautions and uses a blue buckled self release reminder belt when up in the wheelchair. R16 has left side visual deficits. R16's medical records state that R16 removes alarms, is forgetful and impulsive. R16 is assessed as having a poor safety awareness, unsteady gait and with 12 separate fall incidents between 5/23/06 and 6/12/07 (5/23/06, 5/25/06, 5/30/06, 6/05/06, 6/29/06, two separate fall incidents on 10/25/06, 11/11/06, 11/23/06, 01/28/07, 05/26/07 and 6/12/07). R16's 02/15/07 and 5/16/07 restorative notes document that she needs 1:1 assist with transfer, has a lack of safety awareness, and is at risk for falls and injuries. The 5/16/07 note states that R16 needs to use bed and chair alarms. R16's 6/02/07 monthly summary report documented that on 5/22/07, R16 had a CT (computerized tomography) scan of the brain and it revealed new focuses of bleeding; tiny intermittent bleeds in the brain. R16's 12 falls included : 5/23/06 5:00 PM, R16 was left in the bathroom alone by staff and fell while putting her pants on, hitting the left side of her head. Incident report documented that the aide was instructed not to leave R16 alone in the bathroom. 5/25/06 5:00 PM, found on the floor between wheel chair and recliner. R16 fell while trying to rise unassisted. The incident report documented that R16 has poor safety awareness, unsteady gait, history of falls, the chair alarm was not attached and that the nurses were instructed to put the alarm on R16 in the recliner too. R16	F9999		

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F9999	Continued From page 41 sustained a bruise on her right buttocks. 5/30/06 2:00 PM, R16 was found on the floor by the bed saying that she fell getting out of the recliner. R16 sustained an abrasion to her nose. The incident report documented to start one hour checks, continue using the alarms and keep a close watch on resident, she's forgetful and will transfer herself. 6/05/06 3:30 PM, R16 found on the floor face down by the closet in the bathroom. The incident report documented that R16 had a un-witnessed fall from the toilet. R16 sustained bleeding from her nose, a swollen ecchymotic left eye and upper lip and 911 was called. Emergency room evaluation revealed that R16 sustained a left eye hematoma and neck strain. Staff were re-instructed on safety pointers with the R16 and not to leave her alone in the bathroom. 6/29/06 4:15 PM, staff placed R16 on a toilet and left the room and closed the door. The staff heard a loud thump and when the bathroom door was opened R16 was found on the floor near her wheelchair. R16 said that she had hit her buttocks. The incident report documented that R16 was un-safe and should not be left alone in the bathroom. 10/25/06 6:20 PM, R16 was found laying on the floor next to the bed in another resident's room. R16 said that she was trying to put the light on and her knees gave out. 10/25/06 7:00 PM, R16 slid out of her wheel chair while in the dining room. R16 said that she was trying to get up. 11/11/06 1:00 PM, R16 was found on her knees on the floor at her bedside. R16 said she was trying to get into bed. 11/23/06 9:45 AM, R16 was observed rising out of wheelchair, attempting to ambulate and losing her balance and falling. R16 fell backwards and	F9999		

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F9999	Continued From page 42 struck her head on the linen cart and fell onto her buttocks. R16 complained of back pain. 01/28/07 6:30 AM, R16 was found lying on her left side, on the floor, in the dining room. R16 fell and hit her forehead and sustained an abrasion on the left temporal area. R16 said that she was reaching for something and fell. 5/26/07 1:50 PM, R16 was observed kneeling on the floor by the recliner. R16 said she slid off the recliner trying to get her newspaper. The incident report documented that R16's mobility alarm was not attached to the resident and that there was a plastic covered, adult incontinent pad on the seat of her recliner that contributed to R16 sliding out of the chair. The 5/28/07 nurses note states that R16 was complaining of knee and leg pain. 6/12/07 11:00 AM, R16 sustained a fall during an assisted transfer from the wheelchair to the recliner. A volunteer was assisting R16 with the transfer. R16's record included that on 5/29/07 R16 was started on Lovenox injections twice a day for a possible blood clot. R16's current care plan identified falls with injuries as a potential problem related to poor safety awareness, memory deficits, left sided neglect and will attempt to try and rise without assist. Approaches documented for this fall problem included: - Assist with all transfers, 1:1 pivot or mechanical stand assist device when R16 is fatigued. - Place items with-in reach before leaving the room. - Use enablers in bed. - Use bed and chair alarms and be sure to hook alarm to another object as needed for alerting the resident as to when she is rising at other moments.	F9999		

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F9999	Continued From page 43 - May use mat on the floor as needed. On 6/26/07 at 10:00 AM, R16 was observed alone in her room, sitting up in the bedside recliner with a plastic covered adult incontinence pad under her on the seat of the chair, without a chair alarm attached to her and without a call light in reach. Surveyor called E4 (activity aide) into the room and E4 found the call light on the floor behind the recliner. No mat was observed on the floor or at the bedside. 6. On 02/06/07 at 6:45 PM, R3 had a fall and sustained a right hip fracture that required surgical intervention. R3's 02/15/07 restorative note documented that R3 needs extensive assist dressing, transferring, toileting and bathing. R3 has severe cognitive impairments and decreased decision making abilities, is incontinent of bowel and bladder, and is unable to toilet herself. R3's 3/01/07 care plan included at risk for falls as a potential problem with the following approaches: -enabler in bed to aide with transfers and bed/chair alarm use. On 4/03/07 at 7:10 PM, R3 was observed sitting on the floor and leaning on the side of a table. R3 said I wanted to go to bed when I fell. R3's, 4/03/07 nurses notes stated that the chair alarm was not on R3 when she fell. The incident report noted to add offering to put R3 to bed after supper. On 4/29/07 at 7:05 PM, R3 was found on the floor on her left side. R3 said "I just fell." R3 was unable to move her right leg and complained of pain in it. R3's 4/29/07 nurses note stated that R3	F9999		