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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 454	Continued From page 29 E13 (First Shift DSP) was interviewed on 06/27/08 at 12:20 P.M. and confirmed that she was present on 06/019/08 after R1 fell. E13 stated, "I got here at 6:08 A.M.. I remember the time because I clocked in late. I saw R1. They had her head covered. She was bleeding heavy. E7 had to change her pants. I cleaned the floor because there was quite a bit of blood on it." During this interview, E13 stated that she did not use bleach to disinfect the floor. During the Daily Status Meeting on 07/01/08 at 4:30 P.M., E1 (Administrator) was interviewed. E1 stated, "Staff should have followed R1's Hepatitis B protocol as per her plan of care. I would have expected staff to use gloves." During this interview E1 also stated that the facility does not use bleach as a disinfectant.).	W 454		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620b)6) 350.1210a)b) 350.1220b) 350.1230b)3) 350.1230b)7) 350.1230d)1)2) 350.1230e) Section 350.620 Resident Care Policies b) These policies shall include: 6) A written statement for resident care services including physician services, emergency services, personal care and nursing services,	W9999		

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W9999	Continued From page 30 restorative services, activity services, pharmaceutical services, dietary services, social services, resident records, dental services, and diagnostic service (including laboratory and x-ray). Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: a) Physician services including a complete physical examination at least annually and formal arrangements to provide for medical emergencies on a 24 hour, seven day-a-week basis. b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent. Section 350.1220 Physician Services b) The facility shall have a formal arrangement for qualified medical care, including care for medical emergencies on a 24 hour, seven days-a-week basis. An advisory physician shall provide advice on general health conditions and practices of the facility. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in:	W9999		

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W9999	Continued From page 31 3) Periodic re-evaluation of the type, extent, and quality of services and programming. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities. These REGULATIONS are not met as evidenced by: Based on observation, interview, and record review, the facility has failed to provide clients with nursing care in accordance with their needs to prevent medical neglect when they failed to obtain prompt medical treatment for a head injury for 1 of 1 individual in the sample who fell on 06/19/08 at 6:00 A.M., sustaining a laceration to her head with active bleeding, requiring medical treatment (R1). After falling, R1 was not promptly assessed by nursing personnel, nor was the physician notified until approximately one hour after she fell. After returning from the emergency room, R1 was not	W9999		

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closely monitored by staff and fell again on 06/19/08 and again on 06/20/08, sustaining a fracture of her right humerus as a result of one her falls.

The facility failed to:

1) Have a system in place which ensures that direct care staff are able to contact nursing personnel in the event of a serious injury, having the potential to impact 15 of 15 individuals of the facility (R1-R15).

2) Provide necessary supervision to prevent further injury from falls for 1 of 1 individual in the sample (R1) who fractured her left humerus after falling on 05/24/08. After this incident, R1 fell on 06/19/08 and sustained a head injury requiring emergency medical treatment. After returning from the emergency room, R1 fell at 10:45 P.M. on 06/19/08 and again at 1:15 A.M. on 06/20/08.

3) Perform a thorough nursing assessment of the individual, inclusive of vitals and/or a neurological check after each incident of falls for 1 of 1 individual in the sample (R1) who sustained a head injury on 06/19/08 at 6:00 A.M. without an immediate neurological assessment being completed. R1 also fell again on 06/19/08 and again on 06/20/08. No assessment was completed by the nurse immediately after her falls, nor did direct care staff complete vitals after her falls.

4) Up-date and re-assess individuals at risk for falls on a quarterly or on a more frequent, as needed basis for establishing individual fall precautions for 3 of 3 individuals in the sample (R1, R2, and R3) who have been identified by the

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W9999	Continued From page 33 facility to be at a "minimal risk" for falls. Findings include: The Physician Orders dated 04/16/08 thru 05/15/08 states that R1 is a 73 year old female who functions at a profound level of mental retardation and has diagnosis of Kyphoscoliosis. R1 also has an additional diagnosis of being a Hepatitis B Carrier. In reviewing the Nurse's Notes for 05/27/08, R1 fell while at workshop on her left shoulder, sustaining a fracture to the head of the humerus of her left shoulder. Further review of these notes identifies that R1 had open reduction surgery on her left humerus on 06/12/08 and was to be 1:1 with staff with stand-by assistance during the night at the facility. There are no further nursing entries regarding R1's level of supervision after 06/12/08. The facility's policy and procedure for "Abuse and Neglect" defines neglect as, "...A failure in a facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition..." 1) The facility failed to have a system in place which ensures that direct care staff are able to promptly contact nursing personnel in the event of a medical emergency. The Nurse's Notes dated 06/19/08 identifies that at approximately 6:00 A.M., R1 had an unobserved fall in the facility dining room, sustaining a 5 centimeter laceration to the right	W9999		

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side of her forehead.

The facility's Incident Report dated 06/19/08 states, "DSP (Direct Support Staff) (E5) reports she was in the dining area working and heard res (resident) (R1) behind her. Res found lying on floor. DSP unsure how res fell. Res noted having laceration to R (right) forehead. DSP immediately called on-call staff."

Further review of the Incident Report identifies that approximately one hour elapsed before R1 was examined by nursing staff. This report states that R1 was examined by the nurse (E3) at 7:00 A.M., and that the physician (E11) was notified at 7:05 A.M. even though R1 fell at about 6:00 A.M.

E5 (DSP) was interviewed by telephone on 07/01/08 at 1:20 P.M. E5 stated, "I was in the kitchen getting R1 a cup of coffee. R1 was behind me and then I heard her yell. When I turned, she had fallen on the floor. I think she got her house shoe caught on the corner of the kitchen cart. She was bleeding, and we didn't know where she was bleeding from. When we finally got the bleeding stopped we saw that she had split her forehead. There was blood running out of her. There was blood on the floor, and blood on staff's clothes. Once we applied pressure the bleeding slowed down. R1 had blood on her, and I took her to change her clothes. We wrote the incident up and gave it to the nurse (E3)."

During this telephone interview, E5 was questioned about the facility's policy on when to call 911. E5 stated, "We are "NOT" to call 911. We're to call E2 (Assistant Administrator). I can't

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remember who called E2, but they couldn't call the nurse because her number is long distance. We can't make any long distance phone calls from the phone in the kitchen. That's the only phone we have available to call out on." E5 also stated that E7 (Third Shift DSP) and E12 (Cook) were present when R1 fell on 06/19/08 at approximately 6:00 A.M. and that E13 (First Shift DSP) came on duty shortly after.

E7 (Third Shift DSP) was interviewed on 07/01/08 at 8:40 A.M.. E7 stated, "On 06/19/08, I was in the kitchen doing coffee. I did not see her fall. I heard her yell. She was bleeding really bad. I didn't know where the blood was coming from. We got her up and blood was coming from her head, and I put a cold wet towel on her head. Someone called the nurse. I can't remember who, but you can't get ahold of her because her number is long distance. There was blood on the floor and on R1's clothes. I had to change my pants because they had blood on them." At the time E7 was interviewed, E7 stated "No" when asked by the facility if the nurse was called on 06/19/08 after R1 fell. E7 stated, "You can't call her because her number is long distance."

E12 (Cook) was interviewed on 06/27/08 at 11:50 A.M. and stated, "I'm can't remember the day she fell, but it was last week about 6:05 A.M. I was cooking and I see her walking. I heard her yell and she is laying on the floor outside of the kitchen. She was not laying on her bad arm. She was on her right arm. She tried to get up and reach for the chair with her left arm. She was bleeding from her head. There is blood dripping, and she is flipping her head and blood goes all over. E7 and I got her up and carried her so that we wouldn't hurt her bad arm. We

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W9999	Continued From page 36 applied pressure to her head. No, we didn't take her vitals after this incident. The nurse does that." During this interview, E12 was asked about the facility's policy on when to call 911. E12 stated, "You call the nurse, but you can't call the nurse because her number is long distance. We can not call out long distance on this phone. We called 559 -#### and you hear a recording saying that your call can not be completed as dialed, and you have to dial 1-618 and then the number. If you dial it like that, it says your call can not be completed as dialed, please hang up and try again. We called E4 (On-Call Person) and E7 talked with her. We are not to call 911. We are to call the nurse or the person on-call first in the event of an emergency." E13 (First Shift DSP) was interviewed on 06/27/08 at 12:20 P.M. and confirmed that she was present on 06/19/08 after R1 fell. E13 stated, "I got here at 6:08 A.M. I remember the time because I clocked in late. I saw R1. They had her head covered. There was blood everywhere. When E3 (LPN) called the facility, I told her that her how long the injury was. I told her it was about an inch long or from the top of my index finger to the first line. She was bleeding heavy. E7 had to change her pants. I cleaned the floor because there was quite a bit of blood on it. By the time E3 (LPN) came, the bleeding had almost stopped. I'm not sure when she got here." During this interview, E13 was asked about the facility's policy on when staff are to call 911. E13 stated, "We have not been trained to call 911 in the event of an emergency. We are trained to call the on-call person in an emergency. You're	W9999		

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supposed to call the nurse, but the nurse's number is long distance and you can't call her. Then you have to call the on-call person. You can't make long distance calls after the nurse and/or management leaves."

E3 (LPN) was interviewed on 06/27/08 at 11:14 A.M. E3 stated, "I was on my way to work when E2 (Assistant Administrator) called. I told her that I was about twenty minutes out. If it was bad, staff should have called out to 911. Staff are to call the on-call person first so that the on-call person can get ahold of the nurse for them. Both of the nurse's cell phone numbers are long distance." During this interview, E3 stated that the physician was not called until she arrived at approximately 7:00 A.M. and examined R1.

The facility's policy and procedures for "On-Call" dated 06/07/06 identifies, "This policy is to guide staff on the proper procedure for notification of Administration in the event of resident emergency, resident care... On-Call Management staff is only to be contacted by Direct Support Staff's (DSP's) when the QMRP (Qualified Mental Retardation Professional) or Nurse is not present at the facility (this should be between 8 P.M. and 7 A.M.)." This policy further states that "if there is a significant change in a resident's health status, the facility's emergency policy and procedures are to be referred to."

The facility's policy and procedures for Emergency Services dated 04/06/06 identifies "Emergency care shall be available to all residents of this facility 24 hours a day, 7 days per week, and 365 days a year."

In the event of medical emergency, contact the

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W9999	Continued From page 38 resident's physician as soon as possible. If the attending physician can not be reached, contact one of the advisory physicians. If neither the attending nor the advisory physicians can be contacted, contact the hospital directly for on-call physician services and make transportation..." E11 (Physician-Facility's Medical Director) was interviewed by telephone on 07/01/08 at 12:50 P.M. and confirmed that he was not contacted by direct care staff about R1's head injury. E11 stated, "The nurse contacted me about 7:00 A.M.. I wasn't aware that staff could not call the nurse because the phone has a long distance block. If staff are unable to contact the nurse, they should have called me. They have policy and procedures in place, but they are not following these procedures. I should have been contacted." E1 (Administrator) was interviewed on 07/01/08 at 9:55 A.M. an confirmed that direct care staff do not call the physician as per the facility's "Emergency Services" policy. E1 stated, "The facility staff are to call the on-call nurse in an emergency, not the doctor. We have a 911 policy." The facility's policy and procedures entitled "Amendment to On-Call Policy" dated 09/22/05 states, "If a medical issue arises after the nurse on duty has left for the day, the staff is to notify the RN (Registered Nurse) first (not the on-call person) unless the following apply: 1. Hemorrhage. 2. Chest pain. 3. Obvious abnormality of an extremity after a fall.	W9999		

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W9999	Continued From page 39 4. Unconsciousness. When the above occurs, then call 911, then notify the RN." During the Daily Status Meeting on 07/01/08 at 4:30 P.M., the facility's policy and procedures entitled "Amendment to On-Call Policy" was reviewed with E1 (Administrator). E1 stated, "No" when asked by the surveyor if the facility currently had a RN consultant who functions as an on-call person. E1 stated that staff are to call the LPN for medical issues. When E1 was asked how staff could call the LPN when R1 fell? E1 stated, "They couldn't. They would have to call the on-call person and have them call the nurse." E1 also stated that direct staff do not call the physician as identified in the policy and procedures for Emergency Services. E1 then stated, "No" when asked if the Emergency Services policy dated 04/06/06 is currently being used by the facility. 2) The facility failed to provide necessary supervision to prevent further injury from falls. On 06/27/08, the surveyor was presented with a hand written note dated 06/12/08 which corresponds with the date R1 had open reduction surgery on her left humerus. This note states, "8:50 P.M. Attention all staff, R1 is to be one-on-one with staff at all times, In sight. Any problems call E2 (Assistant Administrator), per E15 (LPN) per E2." This note was signed by E14 (DSP). E14 (DSP) was interviewed on 06/27/08 at 3:20	W9999		

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P.M. E14 stated, "After R1 fell in May 2008, her left arm was in a sling and she was off balance. I was concerned about her. I wrote that note (dated 06/12/08) after R1 had surgery on her arm. I don't know why the 1:1 was not continued after that. I was working 2nd shift on 06/19/08 when R1 was brought back to the facility. I was told to watch her every 15 minutes because she was drugged. Well, she had Ativan while she was at the hospital and was groggy. I called E2 and asked her what we were supposed to do with R1. She told me to watch her constantly and write in the shift log. I was told that she could not be one-on-one because it was against her rights. I sat outside her door until I left. No, I didn't do vitals because the blood pressure cuff is locked up in the nurse's station when the nurse leaves. We are not to call 911, but rather the on-call person. You can not call the nurse because we can't call out to her number from the facility's phone."

In reviewing R1's Nurse's Notes from 06/13/08 to 06/19/08, no documentation was noted identifying what level of supervision R1 would need to assist in the prevention of further falls and or injury. On 06/19/08, R1's Nurse's Notes state that R1 fell at about 6:00 A.M., sustaining a 5 centimeter laceration to the right side of her forehead. Further documentation identifies that R1 was sent to the emergency room at 7:30 A.M. R1 returned back to the facility at 11:50 A.M. after receiving 2 milligrams (mg.) of Ativan in the emergency room. At 8:00 P.M. nursing documentation identifies, "...monitored closely per staff."

The Incident Report dated 06/19/08 identifies that R1 fell in her bedroom at 10:45 P.M. without staff

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being present. This report states, "R1 got up out of bed and bumped into her roommate's bed, causing her to fall to her buttocks. Roommate called for staff, who responded and assisted res (resident) to bathroom and put her back to bed. She had no apparent injuries from fall. Staff call(ed) person on-call (E4) who advised them that she would inform the nurse in the A.M."

E9 (Direct Support Staff- 2nd Shift) was interviewed on 07/01/08 at 2:35 P.M. and stated, "I worked the second shift from 2-10 P.M. on 06/19/08. I was off duty when R1 fell. I was waiting on E10 for a ride. R5 came and told us that she (R1) had fallen in her bedroom."

E10 (Direct Support Staff- 2nd Shift) was interviewed on 07/01/08 at 2:45 P.M. and confirmed that he was on duty at the time R1 fell on 06/19/08 at 10:45 P.M. E10 stated, "Yes, I was here (at the facility) when R1 fell. Her roommate (R5) came out of her bedroom and told us that R1 had fallen. We checked her and didn't see that she had hurt herself. We put her back to bed and called E4 (On-Call Staff). She (E4) told us to monitor her every 15 minutes and make sure that she didn't get out of bed by herself because she had been medicated and could fall. E4 also told us to let the nurse know in the morning about R1 falling. We didn't call the nurse because she can't be reached."

R1's special observation form for 06/19/08 was reviewed. This form identifies that R1 was monitored every 15 minutes from 2:45 P.M. until 11:00 P.M.. At 10:45 P.M. this form states, "fell". No further entries were noted after 11:00 P.M. to reflect that staff continued to monitor R1 every 15 minutes or less to prevent further falls.

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	14G351	A. BUILDING _____ B. WING _____	C 07/15/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACHTREE ESTATES	1370 STATE ROUTE 127 SOUTH JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 42 Further review of the incident reports identifies that R1 fell again after she fell on 06/19/08 at 10:45 P.M.. The Incident Report dated 06/20/08 states, "1:15 A.M. ... res. was being assisted to the bathroom. She was very unsteady. She had received 2 mg. of Ativan while at the hospital. Res. pulled away from staff while staff were turning on the light. Res stumbled into and over side of bathtub before staff could stop her. Res was assisted out of tub. This writer was notified that staff noted some swelling (right arm/shoulder) when they assisted res. with shower this A.M." E6 (Direct Support Staff-3rd Shift) was interviewed by telephone on 07/01/08 at 9:10 A.M. E6 stated, "Me and E8 (Direct Support Staff, Non Certified-3rd Shift) heard R1 moaning and groaning. We went into the bedroom and walked her to the bathroom. She was very irritated. When we turned the lights on, R1 pulled away and fell "gently" into the tub, just like in slow motion. We lifted her out. We called E2 (Assistant Administrator). We tried to call the nurse but couldn't get ahold of her. E2 told us to put her back to bed and to monitor her every 15 minutes. I kept her up in the front room with me. I noticed that her shoulder (right) was swollen, and she wouldn't use her right hand. I called the nurse and told her." E8 was interviewed by telephone on 07/01/08 at 2:05 P.M. During this interview, E8 confirmed that R1 was in the hallway by herself prior to being taken to the bathroom by staff. E8 stated, "Truthfully, R1 was headed to the bathroom when we heard her. She was in the hallway, and we assisted her to the bathroom. She fell when we	W9999		

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W9999	Continued From page 43	W9999		

were trying to get her to the bathroom. E6 (Direct Support Staff- 3rd Shift) tried to call the nurse, but you can't call long distance. She talked with E2 (Assistant Administrator). We were told to check on R1 every fifteen minutes, but she was already to be checked on every 15 minute checks before she had fell."

R5 (R1's roommate) was interviewed on 07/01/08 at 12:25 P.M.. R5 stated, "The first time R1 fell, she was in the bedroom. I went and told E9. They (E9 and E10) picked her up and put her back to bed. That was at 10 o'clock (P.M.) The second time she fell was in the bathroom. She was trying to get out of bed and she was hollering and yelling. I went to get staff. She (unsure of staff's name) was asleep on the couch. Two staff took her to the bathroom. My bedroom door was open. I can see in the hall, and I can see the bathroom from my bedroom. They (staff) left her in the bathroom and shut the door on her. They were standing in the hallway by the bathroom talking. I heard R1 yell. They went into the bathroom. R1 had fallen. They picked her up and took her to the front room. They wasn't watching her real close."

According to the facility's staff schedule, E6 and E8 were on duty at the time R1 fell on 06/20/08 at 1:15 A.M.

The facility's policy and procedures for "Resident Supervision and Special Observation" states, "It is the policy of (name of the company stated) to provide the frequency and intensity of supervision necessary for each individual to ensure his or her safety."

E11 (Physician-Facility's Medical Director) was

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W9999	Continued From page 44 interviewed by telephone on 07/01/08 at 12:50 P.M. E11 stated, "I don't necessary think the facility had to put R1 on 1:1 staff monitoring. I would have expected them to at least post a staff person by the door so that they could have kept a close enough eye on her to stop her if she tried to get out of the bed by herself." When E11 was asked if he thought the facility had provided sufficient supervision to R1 on 06/19/08 and 06/20/08 to prevent her from falls, E11 stated, "She fell three times in almost one day, I think that pretty much says it all." 3) Perform a thorough nursing assessment of the individual, inclusive of vitals and/or a neurological check after each falling incident. The facility's policy and procedures for "Neurological Checks" states: "As soon as a head injury occurs: 1) The injury should be immediately reported to the Nurse on Duty. 2) The Nurse on Duty will immediately perform a neurological check, then every 15 minutes for one (1) hour. 3) After the initial hour ...ever 30 minutes. 4) During the third hour, every hour for two hours. 5) During the fifth hour... every four hours for a cumulative total of 24 hours..." This policy does not state what direct staff are to do to assess the individual if the nurse is not on duty. The Nurse's Note dated 06/19/08 identifies that at approximately 6:00 A.M., R1 had an unobserved fall in the facility dining room,	W9999		

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W9999	Continued From page 45 sustaining a 5 centimeter laceration to the right side of her forehead. During the interview with E12 (Cook) on 06/27/08 at 11 :50 A.M., E12 stated, "No, we didn't take her vitals after this incident. The nurse does that." During this interview, E12 also stated, "No" when asked by the surveyor if staff had completed a neurological check on R1 at the time she fell. E3 (LPN) was interviewed on 06/27/08 at 11:14 A.M. and confirmed that no neurological check was immediately done after R1 fell and sustained a head injury on 06/19/08. E3 stated, "I did not get to the facility until about 7:00 A.M. I did a neurological check on R1 when I arrived and R1 was alert. Staff are not trained to do neurological checks." When E3 was questioned as to what staff are to do when an individual falls, E3 stated, "When I called and talked with staff, they had already gotten her up off of the floor. In best practice, when someone falls and hits their head with active bleeding, they should be immediately assessed on the spot. R1 should not have been moved. Staff should have called 911." During a subsequent interview with E3 on 06/27/08 at 3:00 P.M., E3 stated that she had told staff to monitor R1 closely before she left the facility, but R1's neurological checks were not continued by staff after 9:00 P.M. on 06/19/08. The Incident Report dated 06/19/08 states, "10:45 P.M. R1 got up out of bed and bumped into her roommates bed, causing her to fall to her buttocks. Roommate called for staff, who responded and assisted res (resident) to bathroom and put her back to bed. She had no apparent injuries from fall. Staff call(ed) person on-call (E4) who advised them that she would	W9999		

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W9999	Continued From page 46	W9999		

inform the nurse in the A.M." No documentation was provided to the surveyor during the survey dates that would identify that staff thoroughly assessed R1 for injury after she fell.

E10 (Direct Support Staff- 2nd Shift) was interviewed on 07/01/08 at 2:45 P.M. and confirmed that he was on duty at the time R1 fell on 06/19/08 at 10:45 P.M.. E10 stated, "Yes, I was here (at the facility) when R1 fell. Her roommate (R5) came out of her bedroom and told us that R1 had fallen. We checked her and didn't see that she had hurt herself..." During this interview, E10 stated "No" when asked by the surveyor if they had taken R1's vitals after she fell on the floor in her bedroom.

The Incident Report dated 06/20/08 states, "1:15 A.M. ... res. was being assisted to the bathroom. She was very unsteady... Res stumbled into and over side of bathtub before staff could stop her. Res was assisted out of tub..." No documentation was provided to the surveyor during the survey dates that would identify that staff had taken R1's vitals and thoroughly assessed her for injury at the time she fell.

E1 (Administrator) was interviewed on 07/01/08 at 3:30 P.M. E1 stated, "All staff have been trained and know how to take vitals. They should have taken vitals after each one of R1's falls.

4) The facility failed to up-date and re-assess individuals at risk for falls on a quarterly or on a more frequent basis for establishing individual fall precautions.

The Hospital's Short Stay Summary dated

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W9999	Continued From page 47 06/20/08 for R1 states: "Chief Complaint: Fall with right upper extremity pain. History of Present illness: This 73 year old Caucasian female, severe mental retardation and with frequent falls, was admitted through the emergency room .... after she came in with fall resulting in right humerus fracture. Patient also had a previous history of left humerus fracture with recent surgery. The day prior to the admission, patient also had another fall resulting in small laceration on the forehead... Due to her frequent falls resulting in multiple fractures E11 (Physician) requested for inpatient observation for the safety of the patient and nursing home placement. Final Diagnosis: 1. Bilateral Humerus Fracture..." In review of R1's Accident Potential Assessment dated 06/07, this assessment identifies that R1 scored a 6 which places her at a minimal risk for accidents and falls. Areas within this assessment are as followed: Vision - Fair (Cataracts) Score 1. Gross Motor Coordination - Ambulates Good Score 0. Mental Status - Alert Score 0. Environmental Changes - None Score 0. Previous Falls - None Score 0. Communication - No effective skills Score 3. Psychotropic or Controlled Substance- None Score 0. Predisposing Medication Condition - Presents	W9999		

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W9999	Continued From page 48 Moderate Risks Score 2. This assessment recommends that individuals who score from 0-8 be reassessed on a quarterly basis. No further Accident Potential Assessments after 06/07 were noted within R1's file. E3 (LPN) was interviewed on 06/27/08 at 11:14 A.M. and confirmed that no further Accident Potential Assessments were located in R1's file. E3 stated, "R1 has not had another assessment (Accident Potential) since June of 2007. Yes, I would think that R1 should have been re-assessed on a quarterly basis. She is so frail and fragile. R1 is now at a high risks for falls. Her assessment was not updated after she fell on 05/15/08, and no fall precautions were established." During this interview E3 stated that R1, R2, and R3 were at risk for falls. E3 then provided the surveyor with the Accident Potential Assessments for R2 and R3. R2's Accident Potential Assessment is dated 07/28/07 with a score of 7 which places her at a minimal risks for falls. R2 had been observed during the survey dates wearing a helmet and ambulating with a walker and staff assistance. R3's Accident Potential Assessment is dated 09/26/07 with a score of 7. This score places him at a minimal risk for falls. During the survey dates, R3 had been observed wearing a helmet and ambulating with a walker and staff assistance. After reviewing R2's and R3's Accident Potential Assessments with E2, she stated that neither	W9999		