STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146050	A. BUILDING _____ B. WING _____	11/18/2011

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ARCOLA HEALTH CARE CENTER	**422 EAST FOURTH STREET, PO BOX 70 ARCOLA, IL 61910**

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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Federal Oversight and Support Survey (FOSS) Licensure Survey for Subpart S: SMI	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225		11/18/11

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

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F 225	Continued From page 1 representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to immediately report an allegation of staff to resident verbal abuse, to the State Survey and Certification Agency, for one of one residents (R4) reviewed for abuse, in a sample of 16. Findings include: The facility Policy, titled "Abuse Prevention Program" (under Section VII. "External Reporting of Potential Abuse"), states "Initial Reporting of Allegations. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, misappropriation of resident property, and reasonable suspicion of a crime, are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. If the events that cause the reasonable suspicion result in serious bodily injury or suspected criminal sexual abuse, the report shall be made to at least one law enforcement agency of jurisdiction and IDPH (Illinois Department of Public Health) immediately after forming the suspicion (but not later than two hours after forming the suspicion), otherwise, the report must be made not later than 24 hours after forming the suspicion."	F 225		

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F 225	Continued From page 2 An Allegation of Verbal Abuse (Summary), dated 8/15/11, documents that E4 (Certified Nursing Assistant) had allegedly spoken "rudely/hateful" to R4 and an investigation was completed. The Fax Activity Log indicates the State Survey & Certification Agency was notified of the verbal abuse allegation against R4 the following day, on 8/16/11 at 11:54 a.m. On 11/16/11, at 10:15 a.m., E1 (Administrator) stated she first became aware of the allegation of verbal abuse by E4 towards R4 on 8/15/11 at approximately 9:30 a.m. E1 confirmed that the allegation of verbal abuse was not reported to the State Survey & Certification Agency until 8/16/11 at 11:54 a.m., which is more than 27 hours after the allegation was initially reported to E1.	F 225		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop and operationalize policies and procedures that mirror the regulation which requires immediate reporting of alleged abuse to the State Survey & Certification Agency. The current facility policy on Abuse Prevention allows a delay in reporting, of certain allegations of abuse, of up to 24 hours. This failure has the potential to affect all 80 residents living in the	F 226		11/18/11

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F 226	Continued From page 3 facility. Findings include: The facility Policy, titled "Abuse Prevention Program" (under Section VII. "External Reporting of Potential Abuse"), states "Initial Reporting of Allegations. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, misappropriation of resident property, and reasonable suspicion of a crime, are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. If the events that cause the reasonable suspicion result in serious bodily injury or suspected criminal sexual abuse, the report shall be made to at least one law enforcement agency of jurisdiction and IDPH (Illinois Department of Public Health) immediately after forming the suspicion (but not later than two hours after forming the suspicion), otherwise, the report must be made not later than 24 hours after forming the suspicion." An Allegation of Verbal Abuse (Summary), dated 8/15/11, documents that E4 (Certified Nursing Assistant) had allegedly spoken "rudely/hateful" to R4 and an investigation was completed. The Fax Activity Log indicates the State Survey & Certification Agency was notified of the verbal abuse allegation against R4 on 8/16/11 at 11:54 a.m. On 11/16/11, at 10:15 a.m., E1 (Administrator) stated she first became aware of the allegation of verbal abuse by E4 towards R4 on 8/15/11 at approximately 9:30 a.m. E1 confirmed that the	F 226		

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F 226	Continued From page 4 allegation of verbal abuse was not reported to the State Survey & Certification Agency until the following day on 8/16/11 at 11:54 a.m., which is more than 27 hours after the allegation was initially reported to E1. On 11/17/11, at 11:45 a.m., E1 stated that it is the protocol of the facility to report allegations of abuse to the State Survey & Certification Agency within 24 hours of the allegation being made. On 11/16/11, at 2:00 p.m., E2 (Director of Nursing) stated she was uncertain as to when the State Survey & Certification Agency was to be notified of allegations of resident abuse. The Center for Medicare & Medicaid Services 672 form completed on 11-15-11 reflects that there are 80 residents living in the facility.	F 226		
F 253 SS=C	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure areas frequented by the residents (smoking area, dayroom and beauty shop) were kept clean and free from residue. The facility failed to keep resident corridor floors and radiators free from built up wax residue and litter. These failures have the potential to affect all 80 residents residing in the facility.	F 253		1/31/12

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F 253	Continued From page 5 Findings include: The following observations were made during General Observation tour on 11-16-11 between 9:25 A.M. and 11:15 A.M. accompanied by the Maintenance Director, E5 and the Housekeeping and Laundry Director, E6: 1. The back side of the netting on the South side Women's shower chair had brown residue in the corner and along the seat. E6 acknowledged the residue at the time of observation. 2. The South side hot water heat radiators in the corridor, bathing areas, and resident rooms had dust, lint, paper, and other residue in the radiators. E6 stated it has been a while since the radiators had been blown out. 3. The north wall of smoking porch is exterior siding. Built up grim and cigarette burns were present on the siding. The other three walls are a series of connected triple track storm windows. The windows were dirty with dust, lint, and cigarette butts in tracks of the open windows. E6 stated that the smoking area is cleaned daily. 4. The South side day room floor had a black residue between the 12 inch square tiles and on the tiles. The black residue was in all areas of the room,with the heaviest amounts of residue in the northwest corner. E5 acknowledged the black residue is the tile cement. There was black caked on residue behind the soft drink dispensing machine in this room. 5. The South side corridor floors and South side	F 253		

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F 253	Continued From page 6 dining room floors had built up residue along the floor wall junction and at the door jams. The tile finish was dull and marred. The residue had been partially removed along one section with the tile appearing lighter and cleaner. The North side tile floors finish was dull, marred, and had accumulated mop residue. 6. The beauty shop hair dryer filter had caked on dust, lint, and hair care chemical residue. Dust and lint was present on the fan in this room. The electric light above the mirror and sink was loose and not secured to the wall.	F 253		
F 254 SS=B	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that 80 of 155 resident incontinent pads were clean, free stains, fraying, and holes. Findings include: During initial tour on 11-15-11 at 10:20 A.M., three incontinent pads were on R12's bed. One of the pads was stained over 30% of the pad. Two pads were torn and thread bare. The padding was gone leaving just the bottom layer on one of the pads. On 11-17-11 at 11:30 A.M., the Housekeeping and Laundry Supervisor, E6 was asked to do a	F 254		11/25/11

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F 254	Continued From page 7 random condition check of the incontinent pads. E6 reported that her staff found that 80 of 155 incontinent pads with condition issues. The facility's CMS-672 (Resident Census and Condition of Residents) identifies 33 of 80 residents as incontinent of bladder and 24 residents as incontinent of bowel.	F 254		
F 272 SS=B	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding	F 272		12/18/11

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F 272	Continued From page 8 the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to complete Section V of the Minimum Data Set (MDS) for 13 of 16 sampled residents (R1, R2, R3, R4, R6, R8, R9, R10, R11, R12, R13, R14 and R15). Findings include: Section V Care Area Assessment (CAA) Summary was not completed according to the directions. Instructions state to "indicate in the Location and Date of CAA Information column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks, and any referrals for this resident for this care area." The following resident MDS reviews for either Annual or Significant Change Assessment did not have the Section V completed as to the date and location of information: R1 assessment dated 8-29-11 R2 assessment dated 10-17-11 R3 assessment dated 12-24-10	F 272		

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F 272	Continued From page 9 R4 assessment dated 8-15-11 R6 assessment dated 7-21-11 R8 assessment dated 4-1-11 R9 assessment dated 10-19-11 R10 assessment dated 6-13-11 R11 assessment dated 4-8-11 R12 assessment dated 2-25-11 R13 assessment dated 8-19-11 R14 assessment dated 9-23-11 R15 assessment dated 2-25-11 On 11-18-11 at 3:15pm E3, Licensed Practical Nurse, MDS Coordinator stated she did not know what the date and information location was used for on this CAA Summary page. E3 also stated she did not understand why this was needed and wasn't sure if the person helping her understood. E3 stated there may be a few that had this filled in, she wasn't sure.	F 272		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation , interview and record review the facility failed to provide timely toenail care for three of ten residents (R3, R8 and R12) dependent on staff for daily grooming in the sample of 16 and one resident (R57) in the supplemental sample.	F 312		12/18/11

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F 312	Continued From page 10 Findings include: 1. The Physician's Order Sheet (POS) dated November 2011 for R8 identifies R8 as having Insulin Dependent Diabetes. R8's Minimum Data Set (MDS) dated 9/13/11 states R8 is severely cognitively impaired and totally dependent on staff for Activities of Daily Living (ADL's) including nail care. On 11/16/11 at 1 PM R8 had long thick toenails, extending past and curving over the end of his toes. E7, CNA (Certified Nursing Assistant) stated on 11/16/11 at 1:05 PM "The nurses take care of his toenails we (CNA's) don't because he is diabetic." According to the Podiatrist's Consulting Report, R8's last trimming and reduction of the toenails was on 9/12/11. 2. The POS dated November 2011 for R12 lists diagnoses of Bipolar Schizophrenia, Degenerative Spine and Lumbago. The MDS dated 8/9/11 states R12 is moderately impaired in daily decision making skills and requires staff to perform ADL's including toenail care. R12's toenails were seen on 11/16/11 at 9:45 AM during peri care demonstration. R12's toenails on both feet were long and jagged and had not been trimmed. R12's medical record had no documentation when her toenails were last trimmed and reduced. 3. On 11/15/11 at 4:15 PM during Medication Administration Observation R57's toenails were long and thick extending past the end of his toes. The last Podiatrist report dated 9/12/11 documents that R57's toenails were trimmed and	F 312		

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F 312	Continued From page 11 reduced. No further documentation was found regarding R57's toenails being trimmed and reduced. 4. According to the Minimum Data Set dated 08/22/11, R3 is severely cognitively impaired and totally dependent on staff for completion of Activities of Daily Living (ADLs) which includes nail care. On 11/15/11 at 2:20 p.m. R3 had long toenails, extending past the ends of her toes. According to the Podiatrist's Consulting Notes, R3 receives nail care every two to three months. The last trimming and reducing of R3's nails occurred 08/01/11.	F 312		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: A. Based on interview and record review the facility failed to evaluate the effectiveness of interventions following several falls and failed to implement revised interventions to prevent additional falls for one of four residents (R13) reviewed for falls in the sample of 16. R13's fell, sustaining a laceration and a closed head injury. Findings include:	F 323		12/18/11

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The Physician's Order Sheet (POS) dated November 2011 lists the following diagnoses for R13: Schizophrenia, Dementia and Chronic Obstructive Pulmonary Disease (COPD). The Minimum Data Set (MDS) dated 8/16/11 states R13 requires supervision of staff for ambulation and R13's balance is unsteady with impairment of lower extremities on both sides.

The facility's form titled "Resident Fall Tracking Log" for the month of May 2011 indicates that R13 had two falls on 5/10/11 at 5 PM and 10:30 PM and one fall on 5/11/11 at 6:30 AM. The facility's "Investigation Report For Falls" dated 5/10/11 at 5 PM states that R13 had an unwitnessed fall where R13 was trying to reach his oxygen tank on his chair and was found lying on his right side in the fetal position. The form states under the section titled "What new intervention has been implemented to prevent another fall?"-- "Tripped - Acute condition, just returned from the hospital: Pneumonia, COPD, UTI (urinary tract infection) ."

The "Investigation Report For Falls" dated 5/11/11 for the fall R13 had on 5/10/11 at 10:30 PM states R13 had an unwitnessed fall where R13 was messing with the oxygen machine and fell hitting his head on the oxygen concentrator. R13 was found on the floor. The section of the form titled "Root Cause Analysis" states "Acute condition, just returned from hospital with pneumonia." The section titled "What new intervention was implemented to prevent any further falls" states "Patient Education."

The "Investigation Report For Falls" dated 5/11/11 for the 6:30 AM fall states that R13 had

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F 323	Continued From page 13 an unwitnessed fall where he was trying to get up, was found lying on the floor on right side beside the bed. The section titled "Root Cause Analysis" states "(R13) very weak from hospital stay. Acute condition, sent to Emergency Room for Medical ." Section titled "What new intervention was implemented to prevent any further falls?" states "Hospital" R13's Nurses Notes dated 5/11/11 at 6:30 AM states " (R13) is on the floor beside bed mostly lying on right side, had blood dripping from laceration above right brow...complains head, right knee and middle finger on left hand hurting...." Emergency Room Report dated 5/11/11 states that R13 had right frontal scalp hematoma, received two sutures to the laceration and was admitted to the hospital with diagnoses of frequent falls and closed head injury. E2, DON (Director of Nurses) on 11/18/11 at 3:05 PM stated that no new interventions were implemented after the falls and on the third fall "we sent him to the hospital for evaluation." R13's care plan dated 8/30/11 did not show any new interventions for the two falls sustained on 5/10/11 or the fall on 5/11/11. B. Based on observation and interview, the facility failed to ensure that toilet grab bars were secure and safe; failed to ensure that the two toilets were secured to floor; and failed to ensure that the metal defector shield on the hot water base broad heat radiator was secure with no	F 323		

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	146050	A. BUILDING _____ B. WING _____	11/18/2011

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F 323	Continued From page 14 exposed sharp edges. These failures potentially affect 13 of 13 North side male residents (R2, R8, R13, R15, R51, R52, R53, R54, R55, R56, R57, R58, and R59) and 25 of 25 South side male residents (R10, R27, R28, R29, R30, R31, R32, R33, R34, R35, R36, R37, R38, R39, R40, R41, R42, R43, R44, R45, R46, R47, R48, R49, and R50). Findings include: 1. During General Observation tour on 11-16-11 at 9:30 A.M. accompanied by the Maintenance Director, E5 and the Housekeeping Director, E6, the grab bars attached to the toilet seat in the North side Men's toilet room were loose and wobbly. This toilet is accessible to 13 of 13 residents (R2, R8, R13, R15, R51, R52, R53, R54, R55, R56, R57, R58, and R59). 2. During General Observation tour on 11-16-11 at 10:30 A.M., the two toilets in South side Men's shower room were loose, wobbly, and easily moveable. The toilets were not attached firmly to the floor. The toilets are accessible to 25 of 25 residents (R10, R27, R28, R29, R30, R31, R32, R33, R34, R35, R36, R37, R38, R39, R40, R41, R42, R43, R44, R45, R46, R47, R48, R49, and R50). E5 stated at time of observation "there are big boys over here." 3. During General Observation tour on 11-16-11 at 10:35 A.M., the metal defector shield for the hot water heat base broad radiator outside of the South side Medication room (located in the resident dining room) was hanging loose. The shield had exposed sharp edges that could injury a resident.	F 323		

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F 455 SS=F	483.70(b) EMERGENCY ELECTRICAL POWER SYSTEM An emergency electrical power system must supply power adequate at least for lighting all entrances and exits; equipment to maintain the fire detection, alarm, and extinguishing systems; and life support systems in the event the normal electrical supply is interrupted. When life support systems are used, the facility must provide emergency electrical power with an emergency generator (as defined in NFPA 99, Health Care Facilities) that is located on the premises. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, , the facility failed to provide emergency battery backup lighting for eight of eight exit discharges and failed to ensure that the battery operated suction machine functions during an electrical power interruption. These failures potentially affect all 80 residents residing in the facility. Findings include: 1. During General Observation tour accompanied by the Maintenance Director, E5 and the Housekeeping and Laundry Director, E6 on 11-16-11 at 9:30 A.M., the facility emergency exits were observed. The exit discharges (door to the street or public way) did not have battery backup lighting for the discharges outside of the facility. The facility does not have emergency generator and is dependent on batteries for the	F 455		12/18/11

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F 455	Continued From page 16 facility emergency power. The facility has eight designated exits. These exits do not have emergency lighting for the exit discharges if the normal electrical power is interrupted. E5 acknowledged that the facility does not have backup emergency power source for exit discharge lighting. 2. During General Observation tour accompanied by the Director of Nurses, E2, on 11-16-11 at 10:30 A.M., E2 tested the battery backup suction machine. The machine did not function with the battery. E2 was asked if the suction machine was tested on a regular basis to ensure it functions. E2 stated that she does not test it and does not know if anyone else does. The Resident Service Director (Licensed Practical Nurse), E8 identified R2, R8, R15, R41, R60, and R61 with swallowing risk and who may require suctioning. According to the facility's CMS-672 (Resident Census and Condition of Residents), 80 residents reside at the facility.	F 455		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the nurse call station at one of one North side Woman's shower functioned to	F 463		11/25/11

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F 463	Continued From page 17 alert staff and failed to ensure that one of two toilet nurse calls in the South side Woman's shower was capable of alerting staff if a resident had fallen onto the floor. Findings includes: 1. During General Observation tour on 11-16-11 at 9:30 A.M. accompanied by the Maintenance Director, E5 and the Housekeeping and Laundry Director, E6, the North side Woman's shower was observed. The nurse call station toggle switch was broken off and the nurse call could not be activated to alert staff that assistance or help was needed. The toggle had a pull cord but pulling the cord would not activate the call station. E5 acknowledged the shower stall nurse call was not functional. 2. During General Observation tour on 11-16-11 at 10:35 A.M. accompanied by E5 and E6, the South side Woman's shower room was observed. The room has two toilets. The toilet to the north had the nurse call cord wrapped around the wall mounted grab bar. The call could not be activated because the nurse call cord was wrapped around the bar.	F 463		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 465		11/18/11

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F 465	Continued From page 18 Based on observation and record review, the facility failed to ensure that one of one supply storage and mechanical area was maintained in a safe condition to prevent a potentially hazardous situation. This failure affects 37 residents residing on the South corridor. Findings include: During General Observation tour on 11-16-11 on 10:30 A.M. accompanied by the Maintenance Director, E5 and the Housekeeping and Laundry Director, E6, the Housekeeping and Laundry Office located on the South side was observed. The office is used as an office, a storage area, and a mechanical room. An electrical hot water heater was in the southwest corner of the room. The hot water heater was warm to the touch. Two large plastic bags of resident socks were on the east side of the heater and against the heater. A plastic trash container (approximately 13 gallons size) was in the corner and against the heater. The plastic container had oxygen concentrator filters and six spray cans. The spray cans were labeled as containing acetone and glycol ether. The label stated "Do not store near heat, sparks, open flame or other sources of ignition." A cardboard box of toilet paper and a cardboard of cloth mop heads were in front of the heater. The room is located in the center of the south side corridor. According to facility's resident roster, 37 residents reside on the South side corridor.	F 465		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 19 LICENSURE VIOLATIONS 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect	F9999		

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F9999	Continued From page 20 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Theses regulations are not met, as evidenced by the following: Based on interview and record review the facility failed to evaluate the effectiveness of interventions following several falls and failed to implement revised interventions to prevent additional falls for one of four residents (R13) reviewed for falls in the sample of 16. R13's fell, sustaining a laceration and a closed head injury. Findings include: The Physician's Order Sheet (POS) dated November 2011 lists the following diagnoses for R13: Schizophrenia, Dementia and Chronic Obstructive Pulmonary Disease (COPD). The Minimum Data Set (MDS) dated 8/16/11 states R13 requires supervision of staff for ambulation and R13's balance is unsteady with impairment of lower extremities on both sides. The facility's form titled "Resident Fall Tracking Log" for the month of May 2011 indicates that R13 had two falls on 5/10/11 at 5 PM and 10:30 PM and one fall on 5/11/11 at 6:30 AM. The facility's "Investigation Report For Falls" dated 5/10/11 at 5 PM states that R13 had an unwitnessed fall where R13 was trying to reach his oxygen tank on his chair and was found lying on his right side in the fetal position. The form states under the section titled "What new intervention has been implemented to prevent another fall?"-- "Tripped - Acute condition, just	F9999		

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F9999	Continued From page 21 returned from the hospital: Pneumonia, COPD, UTI (urinary tract infection) ." The "Investigation Report For Falls" dated 5/11/11 for the fall R13 had on 5/10/11 at 10:30 PM states R13 had an unwitnessed fall where R13 was messing with the oxygen machine and fell hitting his head on the oxygen concentrator. R13 was found on the floor. The section of the form titled "Root Cause Analysis" states "Acute condition, just returned from hospital with pneumonia." The section titled "What new intervention was implemented to prevent any further falls" states "Patient Education." The "Investigation Report For Falls" dated 5/11/11 for the 6:30 AM fall states that R13 had an unwitnessed fall where he was trying to get up, was found lying on the floor on right side beside the bed. The section titled "Root Cause Analysis" states "(R13) very weak from hospital stay. Acute condition, sent to Emergency Room for Medical ." Section titled "What new intervention was implemented to prevent any further falls?" states "Hospital" R13's Nurses Notes dated 5/11/11 at 6:30 AM states " (R13) is on the floor beside bed mostly lying on right side, had blood dripping from laceration above right brow...complains head, right knee and middle finger on left hand hurting...." Emergency Room Report dated 5/11/11 states that R13 had right frontal scalp hematoma, received two sutures to the laceration and was admitted to the hospital with diagnoses of frequent falls and closed head injury.	F9999		

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F9999	Continued From page 22 E2, DON (Director of Nurses) on 11/18/11 at 3:05 PM stated that no new interventions were implemented after the falls and on the third fall "we sent him to the hospital for evaluation." R13's care plan dated 8/30/11 did not show any new interventions for the two falls sustained on 5/10/11 or the fall on 5/11/11. B	F9999		