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F 520	Continued From page 64 resident's medications on falls, confirmed by interview with Z2 on 11-07-11 at 1:30PM. Z2 stated he had not been invited to the facility QA meetings in 2011. During an interview with E-2 (Director of Nursing) on 11/03/11 at 11:55 AM, E2 stated the facility census was 36.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.690a) 300.1010a)1) 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)6) 300.1220b)2) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies	F9999		

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F9999	Continued From page 65 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. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. Section 300.1010 Medical Care Policies a) Advisory Physician or Medical Advisory Committee 1) There shall be an advisory physician, or a medical advisory committee composed of physicians, who shall be responsible for advising the administrator on the overall medical management of the residents and the staff of the facility. If the facility employs a house physician, he may be the advisory physician. Section 300.1210 General Requirements for	F9999		

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F9999	Continued From page 66 Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. b) The facility shall 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 resident care plan. Adequate and properly supervised 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: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.	F9999		

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F9999	Continued From page 67 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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,	F9999		

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F9999	Continued From page 68 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 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Based on observation, interviews, and record review the facility neglected to comprehensively assess, investigate, and analyze the post fall data to determine the root cause for repeated resident falls. The facility also neglected to implement effective interventions, monitor and modify those interventions to prevent further resident falls. The facility neglected to conduct Quarterly Quality Assessment and Assurance meetings as an organized group from Febuary 2011 to 11-06-11. The facility neglected to identify patterns, trends and causes of resident's falls based on resident accident/incident logs.The facility also neglected to follow their accident prevention program policy/procedure, failed to devise a system of communication, training and implementation for staff to immediately know who is at risk for falls in order to prevent further falls for 7 of 8 residents (R1, R2, R3, R4, R5, R7, and	F9999		

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F9999	Continued From page 69 R8) reviewed at risk for falls in the sample of 8. R1 has had 46 falls since admission 10-20-10 to 10-21-11. R1 fell 8 times in October 2011 with 3 falls resulting in head injuries. R1' s final fall on 10-21-11 resulted in death. R2 had 22 falls from 11-01-10 to 10-21-11. R2's 10-20-11 fall from bed resulted in an unconscious state. The facility failed to assess, investigate and develop effective interventions to prevent R1 and R2 from recurrent falls. R3 through R8 were identified as high and moderate risk for falls and were noted to have repeated falls without identifying, evaluating, implementing, monitoring and modifying effective interventions to prevent further falls. Findings include: 1. R1 is a 78 year old resident admitted with a diagnoses of Alzheimer's Dementia according to the admission face sheet dated 10-20-10. Review of the Minimum Data Set Assessment (MDS) dated 08-09-11 indicates R1 is independent in transfers and ambulation with an unsteady gait at times. This MDS assessment identifies the following: R1's balance as not steady but able to stabilize without human assistance. R1 was also identified to be a wandering risk for elopement daily. R1 was also noted to have physical and verbally abusive aggressive behaviors to others occurring 4 to 6 days but less than daily. R1 has	F9999		

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a short and long term memory problem with moderate cognitive impaired for decision making skills. R1 was assessed to be frequently incontinent of urine and occasionally incontinent of bowel with no toileting program. R1 was assessed to have had 2 or more falls since admission on the last MDS assessment. The fall risk assessment done on 08-08-11 states R1 had a score of 12 which is identified as high risk for falls.

Review of facility's "Occurrence" Reports shows R1's falls as follows: 1 fall in 10/2010, 4 falls in 11/2010, 1 fall in 12/2010, 2 falls in 01/2011, 7 falls in 02/2011, 2 falls in 03/2011, 1 fall 04/2011, 2 falls in 05/2011, 2 falls in 06/2011, 5 falls in 07/2011, 4 falls in 08/2011, 7 falls in 09/2011 and 8 falls in in 10/20/11(total 46 falls since admission).

According to the facility's faxed report to Illinois Department of Public Health on 10-21-11, the report states R1 had a history of falls. The report stated at 11:00AM R1 was observed at the nurses station sitting in a wheel chair with a padded lap cushion and personal alarm in place. Nursing notes on 10-21-11 at 10:20AM states R1 was at the nursing station with bruising noted on both sides of face with laceration to crown of head. Per interview with E7 (License Practical Nurse) on 10-31-11 at 2:15PM, R1 was placed in the wheelchair with the padded lap cushion and personal alarm at the nurses station for supervision on 10-21-11 at 11:00AM . E7 had left the nurses station to administer medications to residents on A Hall and no staff were present at the nurses station located on C Hall when R1 fell. This was an unwitnessed fall. E7 stated R1 was

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able and had removed the padded lap cushion and personal alarm herself before she fell. R1 was found unresponsive on the floor on C Hallway on her back by E1 (Administrator) on 10-21-11 at 11:10AM. Nursing notes dated 10-21-11 at 11:13AM, stated R1 had an old hematoma with blood noted to the back of head. R1's vital signs at 11:13AM were temperature 96, pulse 72, blood pressure 112/76 and oxygen sats were 85%. Oxygen was applied and the ambulance was called. The IDPH report dated 10-21-11 states R1's pupils were fixed and R1 did not respond to verbal stimuli. The nursing notes dated 10-21-11 at 11:23AM state R1's respirations and vital signs were absent when the ambulance arrived. The Emergency Medical Technicians (EMT)started Cardiopulmonary Resuscitation (CPR) for R1, placed her on a cardiac monitor, intubation attempted according to the Emergency Medical Services (EMS) form dated 10-27-11. Z6 (EMT) found R1 to have a do not resuscitate order and CPR was discontinued also according to the EMS form. R1's death certificate dated 10-21-11 states the cause of death is Frequent Falls, Failure to Thrive (2 months) and Advance Dementia with Psychosis (2 years).

Review of the facility's Occurrence Report dated 10-11-11 at 4:30PM, stated R1 was found in the floor in room 12 by another resident. The back of R1's head had a laceration measuring 1 cm x .5 cm with a moderate amount of serous drainage. R1 complained of left hip and right elbow pain. R1 had a scrape to the right elbow and a right forearm bruise noted from the fall. According to the nurses notes dated 10-11-11 at 4:35PM, R1 was transferred to the emergency room. R1

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returned to the facility with a pressure dressing to the head and with instructions for head injury observation. The report did not give a reason for R1's fall only that she independently ambulates with no interventions listed to prevent future falls.

R1's second fall on 10-11-11 was at 8PM according to the Occurrence Report, another resident saw R1 fall back onto her buttocks in the hallway. No injuries or pain was voiced by R1 only that she wanted to go back to bed. There was no investigation of why R1 fell only her status prior to the occurrence was independent ambulation. No preventative measures at the time of occurrence was documented. The only new intervention on R1's care plan dated 10-11-11 states to "involve res in activities of choice".

Review of the Occurrence Report dated 10-12-11 at 5:30PM, stated R1 was ambulating in the rear of the dining room and tripped on wheelchair. The "Investigation of Occurrence" section of the report states R1 "refused to wear shoes or slippers - barefoot". Preventative measures listed were to use a personal alarm while in bed and 15 minute checks, neither of these approaches were new interventions. The conclusion stated R1 fell after getting up out of bed, sent to emergency room for further treatment and returned to facility and moved closer to nurses station. Corrective actions taken on the report was coded "NA". R1's care plan approach for 10-12-11 was to "involve her in her own care approach in a warm way".

Review of the Occurrence Report stated, R1 fell again on 10-14-11 at 10:15AM, resident "found lying in floor in her room on her back, no shirt on,

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lying with head on blanket. Right crown of head had small amount of blood with a small bump beside abrasion". The report describes the injury was "2 cm x 2 cm superficial - recurrence". The investigation portion of the occurrence report states R1 refuses to use shoes with no preventative measures listed or corrective actions taken. The root cause of the incident was "no fault" with no conclusion. No new interventions were noted on R1's care plan dated 08-08-11 only to "be attentive to resident needs".

According to nursing notes on 10-16-11 at 9:45AM, R1 was found lying on her left side on the floor in the back of the dining room. R1 denies pain and range of motion is normal limits. No occurrence report was found and no investigation of environmental factors was done, confirmed by interview with E2 (Director Nursing) on 11-07-11 at 3PM. This fall was not on the facility's monthly incident/accident log and analysis. No new interventions were included on R1's current care plan after this fall.

R1 fell on 10-19-11 at 3:57PM according to the facility's Occurrence Report. R1 was found on the dining room floor by a staff member. the report indicates R1 sustained an abrasion that was treated with an ice pack. The report does not indicate where the abrasion was located or any preventive measures in place at the time of occurrence. Preventative measures listed on the report state to use a personal alarm while in bed (this was a previous intervention and not applicable to this type of fall).

R1 fell again on 10-19-11 at 7:30PM according to the Occurrence Report resulting in head trauma,

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bruise and a laceration (no description). R1 was found by a staff member on the floor in her room. No investigation of why or how this resident fell. The report states R1 was independent with ambulation prior to occurrence and the call light was in reach. R1 was sent to the emergency room for further evaluation. The emergency room report dated 10-19-11 stated R1 sustained a hematoma to the right elbow and bleeding from an abrasion on the back of the scalp from another recent fall. Z1 (Physician) stated in R1's "Emergency Room Note" dated 10-19-11, "Advisement for fall precautions was ordered". No new interventions were added to R1's care plan only to place a personal alarm while in bed (previous intervention). No indication if the personal alarm was on R1 while in bed prior to this fall.

Review summary of R1's six September 2011 falls (from Occurrence Report with corresponding dated): 2 falls occurred on the 6AM to 2PM shift (09-02-11 9AM and 09-14-11 6AM). Four of R1's falls occurred on the 2PM to 10PM shift (09-14-11 3:05PM, 09-15-11 at 7PM, 09-16-11 6:30PM and 09-18-11 at 7:45PM). Two falls involved R1 either toileting herself or removing her adult incontinent brief (09-15-11 7PM and 09-18-11 7:45PM). Neuro checks were ordered by the physician on 09-14-11 after the second fall 3:05PM. The fall on 09-16-11 at 6:30PM states R1 left hand was swollen and was sent to emergency room for xrays (no fracture). None of the fall occurrence reports included thorough investigations to determine the cause of R1's falls and no new interventions were initiated for R1 to prevent further falls from occurring, this was

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F9999	Continued From page 75 confirmed by interview with E2 on 11-02-11 at 11:30AM. R1's physician's order dated 10-20-11 stated "may be up in wheelchair with a padded lap cushion and non restraint personal alarm related to frequent falls, unsteady gait and weakness". No assessment was completed for this restraint or any other alternatives attempted. The fact that R1 could remove the padded lap cushion and personal alarm was not identified in the clinical record. Per interview with E7 (License Practical Nurse) on 10-31-11 at 2:15PM, R1 was placed in the wheelchair with the padded lap cushion and personal alarm at the nurses station for supervision on 10-21-11 at 11:00AM and could remove the lap cushion. Review of R1's current October physician's order sheet states R1 is on the following multiple antipsychotic medications: ordered 03-27-11 Abilify 10 mg at 4PM, 04-05-11 Risperidone 1mg daily, 05-17-11 Saphris 5 mg sublingual twice a day, and 06-13-11 Haldol injection 2ml (10mg) every 6 hours as needed. R1 is also on the antianxiety medication Lorazepam .5mg four times a day ordered 03-29-11 and Lorazepam 1mg three times a day as needed. R1 is on the antihypnotic Zolpidem Tartrate 10mg one at bedtime since 04-04-11. The recommended dosage for elderly for Zolpidem Tartrate is 5mg according to the Drug Information Handbook for Nursing 2007 addition. Z2 (Pharmacist) made a recommendation to Z1 (Physician) on 05-24-11 and 10-19-11 stating that Zolpidem 10mg every bedtime routinely is not indicated for the long - term use or treatment for insomnia. Please	F9999		

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F9999	Continued From page 76 review and assess the continued routine use of Zolpidem and possibly a trial of Zolpidem PRN. Z2 also stated the maximum recommended dose of Zolpidem in the elderly is 5mg. Per interview with Z2 on 11-07-11 stated he could not recall R1's medications but stated any recommendations should be documented in R1's clinical record. Z2 was not made aware of R1's falls or if there were any problems with falls and medications, it should be noted on the monthly "Consultant Pharmacist Medication Regimen Review Log". No mention of R1's falls were noted on the log. Z2 did state on 05-24-11 and 08-25-11 that Zolpidem routine was addressed. Z2 did agree per interview that the Haldol 10mg IM dose and the Zolpidem Tartrate 10mg were increased doses over elderly recommendations. Interview with E2 (DON since 10-12-11 and past MDS/Care Plan Coordinator) on 11-02-11 at 11:30AM stated she was aware of R1's falls and put interventions on the care plan. E2 stated she did not have a comprehensive assessment for the patterns/trends or causes of R1's numerous falls. E2 also stated she had not attended any fall meetings in the past few months. E2 stated she felt the facility did all they could to prevent R1 from falling. The facility's "Accident Prevention Program" revised on October 2008 with another facility's name on the heading stated: B. Appropriate Fall Prevention Precautions: 3. Resident receiving medication will be monitored to determine the impact of the medication on their ability to ambulate. 5. Incident/Accident Reports will be reviewed during the weekly fall meeting. Appropriate interventions and or recommendations will be taken/made as needed.	F9999		

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2. A review of the facilities Occurrence Reports , dated November 01, 2010 through October 31, 2011, notes R-2 has fallen 22 times. A Transfer Sheet dated 10/20/ 11 at 10:55 PM , notes R-2 was found on the floor, beside his bed, with his head on the bottom of a bed side table. The Transfer Sheet notes, R-2 was unresponsive for approximately one minute. Nurses notes dated 10/20/11 at 11:00 PM, note the call light was sounding when staff entered the room and R-2 was laying on the floor, unresponsive. Nurses notes dated 10/20/11 state R-2 was transferred to the hospital at 11:00 PM complaining of pain in the right arm, elbow, shoulder , hip and rib. The emergency room report noted R-2 had no fractures and was sent back to the facility at approximately 1:20 AM. The current Care Plan dated 08/23/11 regarding falls lists a new intervention dated 10/20/11 that staff will encourage rest periods for R-2.

Fall Occurrence Reports note R-2 fell five times in February 2011, five times in March 2011 and nine times in April 2011. The April 2011 Fall Occurrence Reports notes R-2 fell out of bed three times in nine days: on 04/04/11 at 7:30 AM, 04/10/11 at 10:30 PM, and 04/12/11 at 0445 AM. A Telephone Order dated 04/10/11 and 04/12/11 note R-2 was sent to the emergency room for an evaluation both times. The Occurrence Reports note on 04/10/11 and 04/12/11 , R-2 removed a personal alarm and fell out of bed both times attempting to go to the bathroom. The current care plan dated 08/23/11, notes on 04/05/11 in the problem section that R-2 removes the body alarm. The Actions taken report dated 04/10/11 notes R-2 removed the

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alarm and fell trying to go to the bathroom. An alarm was applied and non-slip socks/shoes applied. The Occurrence Report dated 04/12/11 at 10:00 PM notes R-2 removed the alarm to go to the bathroom and fell. The report states staff will continue to monitor the resident and a bed alarm was applied. The 04/12/11 Actions take report notes An alarm was applied and non slip socks, it also notes R-2 is too weak to walk alone. The Fall Investigation Report dated 04/12/11 notes R-2 is weak , confused and had many medications discontinued. The conclusion report of 04/12/11 notes a bed alarm will be used while R-2 is in bed. The reports and Care Plan do not address the statement that R-2 removed the alarm to go to the bathroom.

The interventions for falls on R-2 's current care plan dated 08/23/11 include: 1. Fall risk assessments will be done quarterly and as needed . 2. Monitor residents for side effects of antipsychotic medications 3. Keep environment hazard free. 4. Notify doctor of problems. 5. Administer first aid 6. Added 08/13/11, ensure shoes fit properly 7. Added 10/20/11, encourage rest periods 8. Personal alarm, call light in reach. In the Problem section of this care plan a note dated 04/05/11 notes resident removes body alarm . A personal alarm was unattached and laying on the bed side table while R-2 was laying in bed on 11/03/11 at 9:30 AM and 3:30 PM.

A Quarterly fall risk assessment completed on on 05/12/11 identified R-2 at high risk for falls. A history and physical report dated 04/12/11, states R-2 has a diagnosis of Dementia Depression , Prostatitis and Chronic Low Back Pain. The report states this is the second day R-2 went to

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the emergency room with multiple falls. The Assessment section of the History and Physical report notes , R-2 has multiple falls, most probably secondary to medication. The Plan section of the History and Physical also notes the following medications were discontinued while R-2 was in the hospital: OxyContin, Risperidone, Ativan and Temazepam was changed from routine administration to an as needed administration. The current Medication Administration Record dated 10/01/11, notes Temazepam was still being administered ,one 30 milligram tablet every evening. The physician order was dated 04/03/11. A Consultant Pharmacist's Medication Regimen Review Communication, addressed to the facility, dated 02/12/11 notes Temazepam 30 milligrams is not indicated for long term use in elderly patients. The maximum recommended dose of Temazepam in the elderly is 15 milligrams. Please review and assess the continued, routine use of Temazepam. In the response section of this correspondence the Physician did not indicated if he agreed or disagreed with the pharmacists recommendations nor did he sign it. On 07/21/11 an identical letter was issued to the facility from the consultant pharmacist , regarding the Temazepam for R-2. The 07/21/11 letter was signed by the doctor indicating that he agreed with the pharmacists recommendations. During an observation on 11/02/11 at 4:30 PM, the medication administration record dated 11/01/11, notes R-2 is receiving Temazepam 30 milligram, one tablet every evening. The unit dose card with R-2's name on it, notes one tablet of Temazepam 30 milligrams should be administered to R-2 one time a day at bedtime. E-2 (Director of Nursing) was present during this

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observation and confirmed the Temazepam was 30 milligrams. E-2 stated she thought the Temazepam had been reduced to 15 milligrams.

The Minimum Data Set 3.0 (MDS) dated 06/01/11 ,section C notes R-2 has disorganized thinking continually. Section E notes R-2 wandered daily. Section G notes R-2 needs one person to physically assist with transfers, ambulation in hall way, and toilet use and R-2's balance is not steady but is able to stabilize without human assistance. Section I notes R-2 has diagnosis of Renal Insufficiency, Dementia and Depression. Section J notes R-2 has moderate pain,. almost constantly and falls. Section M notes an infection of the foot with purulent drainage. Section N notes R-2 receives Antidepressants, Antipsychotics, Hypnotics and Diuretic medications. The 08/23/11 MDS Section G notes R-2 still requires one person to physically assist R-2 with transfers, ambulation in the hall and toilet use.

The facility Accident Prevention Program Policies and Procedures dated 10/08; Paragraph number 2 notes if resident is considered high risk for potential falls, this assessment will be documented in the care plan and goal developed to reduce/prevent falls . R-2's current care plan dated 08/23/11, did not identify that R-2 was high risk for falls as indicated on the 05/24/11, Fall Assessment. Part B, 3. of the facilities policy states residents receiving medications will be monitored to determine the impact of the medication on their ability to ambulate. R-2's falls related to medications were identified by the doctor during a second visit to the emergency

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room 04/12/11 for multiple falls.. The History and Physical Assessment section states Multiple falls, most probably secondary to medication. OxyContin, Ativan and Risperdal were stopped and Temazepam was reduced according to the History and Physical Plan on 04/12/11. During an interview with Z-2 (Pharmacist) on 11/10/11 at 10:20 AM, he stated he relied on the Director of Nursing to identify residents who were having frequent falls. He stated If he was aware of residents having frequent falls related to medication he would document that in his notes. Z-2 also stated he has dealt with three different Directors of Nursing in the last six months. Z-2 stated this makes communication and continuity very difficult. The Consultant Pharmacist Medication Regimen Review Logs 02/15/11 through 10/19/11 do not identify R-2 having issues with frequent falls.

The Accident Prevention Program Policy section 5. states Incident/ Accident Reports will be reviewed during the weekly fall meeting. Appropriate interventions and or recommendations will be taken/made as needed. E-2 (Director of Nursing) confirmed during an interview on 11/03/11 at 11:55 AM, that no weekly staff meetings were occurring to discuss falls since May 2011 , when she became employed at the facility as the MDS coordinator.

3. R3 was admitted on 05-04-11 with diagnoses of Senile dementia and Weakness according to the admission face sheet. R3 was assessed per MDS dated 08-03-11 to require supervision and 2 staff person assist for transfers and ambulation. R3 was assessed to be continent of bowel and

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bladder. R3 was assessed by E2 on 08-02-11 not to be at risk for falls according to the facility's " Fall Risk Assessment". R3 "Physical Restraint Elimination Assessment" form done on 08-02-11 states R3 needs one siderail raised for bed mobility and positioning. Per interview with E2 on 11-03-11 2:50PM, stated R3 had one full siderail raised on the right side of the bed and the left side of the bed was against the room wall. On 08-20-11 4:30AM Occurrence Report states R3 was found in sitting in the floor by her bed on buttocks with the siderail in the raised position and the call light was on. The report states R3 had no injuries. No conclusion or interventions were noted on the report. R5's care plan dated 08-20-11 stated to assist resident with toileting every 2 hours and as needed. No change or reassessment for R3's need for a full siderail.

R3 had a 2nd fall on 09-12-11 at 4PM, where R3 was found lying on the floor in her room. The Occurrence Report stated R3 was getting out of chair did not use the call light or walker no injuries were noted. At 10PM on 09-12-11, R3's left wrist had edema and she complained of pain in the left wrist and hip. R3 was sent to the hospital and a fractured left wrist and hip was noted. No indication if R3 had been toileted or if any preventative fall interventions were in place. R3 did not return to this facility after surgical intervention.

R3 was noted to be on several antipsychotic medications. On the September physician's plan of care, R3 was on Ativan 1mg daily, Tranxene 7.5mg 3 times a day and Trazodone 50mg at bedtime since admission 05-04-11. These meds were discontinued on 09-07-11 and Ativan 2mg 3

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F9999	Continued From page 83 times a day and Seroquel 25 mg at bedtime were started. Ativan 1mg Intramuscular (IM) injection was given one time on 09-05-11 for increased anxiety and Haldol 5 mg IM one time on 08-26-11. Z2 (Pharmacist) reviewed R3's medications on 08-25-11 on the "Consultant Pharmacist Medication Regimen Review Log" and no indication that Z2 was aware of R3's fall. No assessment was completed to determine if R3's antipsychotic medications had any effect on R3's falls. 4. Review of the facility's Occurrence Reports for R4 indicates four falls since admission on 10-18-11, according to the admission face sheet. A) The first fall report was noted on 10-21-11 when R4 rolled out of bed. No injury was sustained. R4 was noted to be oriented X 3 and told the nurse he was too close to the edge of the bed and rolled off. The conclusion to the occurrence investigation was implement 15 minute checks, continue reorientation to environment, and encourage to use call light. B) The second fall report was noted on 10-22-11 when R4 was found on the floor in his room. No injury was sustained. R4 stated he fell off the side of the bed attempting to get back in bed after going to the rest room. The conclusion to the investigation was to put a wedge in place to assist with keeping the resident from rolling out and encourage to use call light. C) The third fall report was 10-30-11 when R4 was found on the floor of his room. No injury was sustained. The conclusion to the occurrence investigation states R4 tripped over oxygen tubing. Also noted is staff are to encourage the resident to use the call light	F9999		

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for assistance and ensure it is in reach, provide reorientation frequently and 15 minute checks. D) The fourth fall report was 11-2-11 when R4 was found on the floor in his room holding his head. R4 sustained a laceration to the right crown with a large amount of blood noted from head. R4 was sent to the emergency room for evaluation. The oxygen tubing was noted wrapped/tangled around his feet. The conclusion to the investigation indicates R4 reported getting his feet tangled in oxygen tubing and falling. (Second time the oxygen tubing caused R4 to fall). Implementation included shorter oxygen tubing on the concentrator, wedge on the outside edge of bed for positioning and safety and a personal alarm intact while in bed.

5. Review of the facility's Occurrence Reports for R5 indicates a fall on 7-12-11 when R5 slid out of her wheel chair in a common area. An abrasion to her back was sustained. The occurrence investigation conclusion was blank. The report fails to indicate if the fall was witnessed and if any measures were implemented to prevent future falls of this type.

6. Review of the facility's Occurrence Reports for R7 indicates eight falls since admission 3-07-11 according to the admission face sheet. A) The first fall report was on 3-11-11 when R7 got up to go to the bathroom and lost her balance. A small bump was sustained to the back of her head. The conclusion to the occurrence investigation notes the call light was in reach and R7 did not use. Implementation included to have R7 ask for assistance when using restroom. B) The second fall report is dated 3-18-11 when the resident was found sitting on the floor in the dining room. No

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injury was sustained. The resident stated she missed her chair when she sat down. No interventions were implemented. C) The third fall report is dated 4-4-11 when R7 tripped coming out of the bathroom in her room. An abrasion to her left shoulder was sustained. Poor fitting shoes were noted as footwear at time of the fall. The conclusion to the occurrence investigation indicates to encourage resident to be careful and ask for assistance if needed. D) The fourth fall reports is dated 5-21-11 when she fell in her room. No injury was sustained. The conclusion report notes R7 states she slipped off the edge of the bed and just sat down. Implementation included encouraging resident to call for help when getting up. E) The fifth fall report is dated 6-23-11 when R7 fell in her room when going to the bath room at 2320. No injury was sustained. R7 failed to use her call light. The conclusion report does not include any interventions. F) The sixth fall is dated 7-28-11 when R7 fell in her room at 2415. R7 complained of pain all over. R7 was sent out for evaluation. A bruised hip was diagnosed. The conclusion report does not note any interventions to prevent future falls of this type. G) The seventh fall report is dated 8-16-11 when R7 fell in her room near the bathroom at 12AM. A bump on the back of her head and abrasions to the left hip and right ankle were noted. The conclusion failed to identify risk factors or implement interventions to prevent future falling. H) The eighth fall report is dated 10-29-11 when R7 slipped in urine in her bathroom at 1930. R7 was sent to the emergency room for an evaluation. No injuries were noted. The conclusion report notes to encourage resident to use the call light and have it in reach at all times, assist to the toilet often

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and be attentive to resident needs.

7. Review of the facility's Occurrence Reports for R8 indicates four falls since admission 5-11-11. The admission sheet in the medical record notes a diagnosis of a Fractured Hip and Alzheimer's Disease. A) The first fall report is dated 7-1-11 at 12:15PM when R8 was heard calling out and found on the floor in their room. No injury was sustained. A conclusion to the fall was not addressed. No preventive measures were noted to prevent future falling. B) The second fall report is dated 7-1-11 at 11:25PM when R8 was found on the floor by the doorway in their room. No injury was sustained. A conclusion to the fall was not addressed and no preventive measures were noted to prevent future falling. C) The third fall report is dated 7-5-11 at 2201 when R8 was found in the floor by the end of her bed. No injury was sustained. A personal alarm was noted as sounding. A conclusion of the fall was not addressed and no plans were noted to try and prevent future falling. D) The fourth fall report is dated 8-14-11 when R8 was found on the floor in their room. No injury was sustained. There was no documentation on the Occurrence Report noting if the personal alarm was on R8 or sounding.

The Comprehensive Plans of Care in the care plan book for R4 (dated 10-19-11), R7 (dated 3-7-11 and 9-20-11) and R8 (dated 5-24-11 and 8-23-11) note a potential/history of falls. The first approach listed states to gather information on past falls and attempt to determine cause of falls. Anticipate and intervene to prevent future recurrence. The Comprehensive Plan of Care for R5 (dated 7-5-11 and 10-4-11) notes a history of

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F9999	Continued From page 87 falls and potential for falls due to receiving antianxiety therapy. The first intervention noted is a Fall risk assessment to be done on admission, quarterly and PRN (as needed). The facility's failure to implement the Comprehensive Plans of Care, identify and assess risk factors for falls and failure to implement safety measures to try and prevent future falls was discussed with E1, (Administrator), at 3PM on 11-10-11. 8. Interview with E1 on 11-03-11 at 2:10PM stated he could not locate any Quality Assurance Meetings Minutes for the past year. E1 stated he thought there was a meeting in July or August but could not recall any problems identified regarding falls. E1 stated all Department Heads, Medical Director and Consultant Pharmacist were invited to attend these meetings. E1 identified E2, E8 and Z3 as attending this July/August Quality Assurance Meeting. Interview with E2 and E8 on 11-03-11 at 2:30PM, both staff stated they did not attend a Quality Assurance Meeting in July/August or any time since January 2011. Interview with E3 (Maintenance Supervisor) and E4 (Housekeeping Supervisor) on 11-21-11 at 11:15AM stated neither one had attended a quality assurance meeting since Jan. 2011. Interview with Z3 (Medical Director) on 11-10-11 at 11:30AM, he stated he has not attended a Quality Assurance Meeting at this facility since January 2011. Z3 stated he was not aware of a problem with resident repeated falls at this facility. No weekly fall review meetings have occurred for several months according to interview wit E1 on 11-03-11 at 2:10PM. No interdisciplinary team discussions have occurred regarding	F9999		

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F9999	Continued From page 88 patterns/trends of individual resident falls to provide effective interventions. No interdisciplinary team reviews of all resident falls for each month to determine a facility wide problem time or area causing an increase in resident falls have been determined. This was confirmed with interviews with E1 and E2 at 11-10-11 at 3:20PM. The facility has had no communication with Z2 (Pharmacist) regarding resident falls and a subsequent pharmacy review of medications effect on resident falls, confirmed by interview with Z2 on 11-07-11 at 1:30PM. Z2 had not been invited to the facility QA meetings either. (A)	F9999		