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F 520	Continued From page 32 Therefore, an analysis for patterns, trends and causes of the residents falls was not completed. On 3/14/12 at 10:30am, E8 (Medical Director) stated he was not aware of the falls identified by the facility. E1 and E2 both stated E7 (Pharmacy Consultant) attended the Quality Assurance Meetings on 10/26/11 and 1/25/12. E7 was also unaware of the correct fall data and failed to analyze the possibility of medication issues related to the residents fall and to prevent further residents falls.	F 520		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.610a) 300.1210a) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a	F9999		

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F9999	Continued From page 33 meeting. Section 300.1210 General Requirements for 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. 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	F9999		

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F9999	Continued From page 34 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 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. This Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to accurately and comprehensively assess, investigate and analyze the precipitating factors and post fall data to determine the root cause for repeated resident falls. The facility also failed to implement effective interventions, monitor and modify those interventions to prevent further resident falls and injury. The facility further failed to devise a program of communication, training and implementation for staff to immediately know who	F9999		

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is at risk for falls and means to prevent further falls for 7 (R3, R7, R9, R10, R11, R12 and R13) of 10 residents reviewed at risk for falls in the sample of 16.

R9 has fallen 28 times since admission on 6/25/11 to 3/14/12. R9's 28 falls resulted in 8 injuries (1 abrasion to the head, 3 lacerations to the head, 3 hematomas and a fractured left wrist).

R10 has fallen 8 times since admission on 5/11/11 to 3/14/12. R10's 8 falls resulted in 5 injuries (1 bruise, 1 hematoma, 2 lacerations and a reddened area).

R11 was admitted on 6/15/10 and in the past 4 months has fallen twice. One of R11's falls resulted in a fractured right hip.

R3 has fallen 10 times since admission on 10/6/11 to 3/14/12. R3's 10 falls resulted in 1 injury of skin tears.

R12 was admitted on 2/16/08 and since 10/27/11 to 3/14/12 R12 has fallen 4 times. R12's falls resulted in 2 injuries (a skin tear and a fractured right hip).

R13 has fallen 19 times since admission on 9/27/11 to 3/14/12. R13's falls resulted in 1 injury (abrasions). R13's fall analyze and interventions have failed to provide a means to prevent additional falls.

R7 has fallen 1 time on 2/4/12. R7's fall resulted in a fracture of the distal coccyx. The fall analysis failed to put into place related and effective

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interventions.

The facility failed to assess, monitor and implement effective interventions to prevent repetitive falls and injury for R9.

R# 's 3, 7, 10, 11, 12 and 13 were identified at risk for falls and were noted to have repeated falls and injuries. The fall investigations failed to provide accurate analysis and interventions to prevent further falls.

The findings include:

1. Admission records for R9 find an admission date of 6/25/11 with diagnosis of Fatigue, Hypertension, Diabetes Mellitus Type II, Dementia, Hypernatremia, Anxiety, Falls, Paranoia, Hyperlipidemia, Low Potassium and Headaches. R9's Assessment for Accident Risk from admission to 2/29/12 indicated R9 was always at risk of falling (scores of 17 to 21). The assessment states "If score over 8, Resident has a risk of falling". R9's 7/1/11 initial Minimum Data Set assessed ambulation as a 2/2 (limited assistance/ 1 person physical assistance). R9's Brief Interview for Mental Status indicated a 3 (Significantly Impaired). R9's admission records state R9 was initially placed on the Auten Center (dementia care unit). A Care Plan dated 6/27/11 was in place for increased risk of falls. R9's current March 2012 physician's orders find R9 is prescribed Restoril 15mg one time daily since 8/5/11 , Seroquel 50mg 1 tab at bedtime since 9/13/11, Celexa 20 mg 1 tab daily since

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11/8/11 and Xanax 1mg tab 3 times daily since 8/25/11. Consultant Pharmacist Gradual Dose Reduction requests on 11/11/11 for the Xanax and Restoril were denied by R9's physician. There are no notations in the Consultant Pharmacists Audit Log to indicate that R9's numerous falls have been considered in relationship to the medications prescribed to R9. Resident Incident Reports beginning on 7/10/11 and continuing to 2/24/12 find R9 had 28 falls with 8 injuries.

1) 7/10/11 fall at 5:20 pm in resident bathroom -- intervention added to care plan, 15 minute checks.

2) 8/1/11 fall at 10:05pm in Auten center TV area - laceration to forehead -- intervention added to care plan, light on when in bed and Restoril for insomnia.

3) 8/2/11 fall at 10:15pm in resident room, attempting to sit on a chair- abrasion to the top of head-- intervention added a floor pad by the bed.

4) 8/30/11 fall at 8:15am in Auten dining room, attempting to sit on a chair-- hit bottom hard on the floor-- back Xray on 8/31/11-- interventions on incident report Vicodin for pain and neurological checks for 48 hours and continued therapy--there are no other interventions on the care plan.

5) 9/9/11 fall at 6:15am in Auten TV area -- hematoma to the left forehead-- sent to the Emergency room-- there were no new interventions on the incident report or care plan to prevent further falls.

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F9999	Continued From page 38 6) 10/1/11 fall at 5:10pm at Auten Nurses Station-- attempting to sit in a recliner, set on the floor --The incident report states the new interventions are: use of an under bed alarm, behavioral monitoring, 30 minute checks, assisted ambulation and continued redirection with behaviors-- The fall and interventions from the incident report are not on the Fall interventions in the care plan. 7) 10/7/11 fall at 8:05pm in Auten Center Hallway-- slid to floor down the wall--interventions noted on the incident report: monitor gait pattern and use gaitbelt-- The fall and interventions from the incident report are not on the Fall interventions in thecare plan. 8) 10/8/11 fall at 4:50am in resident room at bedside, under bed alarm sounding--The incident report states new interventions are: 30 minute checks, nonskid mat, bed alarm, resident education, assisted ambulation, concave mattress and grab bars to bed.-- The fall and interventions from the incident report are not on the Fall interventions in the care plan. 9) 10/9/11 fall at 9:50am in Auten Center TV area--on knees with face in the seat of the recliner, resident ambulating with unsteady gait and refused to sit down-- The incident report stated the physician sent R9 to the Emergency Room (ER) for observation due to the three falls in 24 hours.--The incident report interventions added after the ER were fall precautions (not identified specifically) ambulation with assist and non skid mat, monitor closely.--The fall and intervention from the incident report are not on the Fall interventions in thecare plan.	F9999		

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10) 10/18/11 at 1:30am in the resident room, alarm sounding-- resident on the floor--The incident report interventions added :15 minute checks, white clip in wheelchair, staff to address toileting every 2 hours and PRN (as needed), resident to voice needs, up with assist.-- The fall and interventions are not on the Fall interventions in the care plan. However a note on the Care Plan from 10/18/11 states D/C skilled PT, max.

11) 10/21/11 at 6:15pm at the Wesley I nurses station, resident wheelchair alarm sounding and resident noted falling to floor -- laceration to forehead--There was no investigation, no interventions and Care Plan additions for this fall with injury.

12) 10/24/11 at 8:55am at the Wesley I unit clerk desk--clerk heard alarm sound and saw resident fall to the floor. Laceration noted to R9's upper forehead. R9 was sent to the ER for evaluation returned with steri-strips. The incident form did not state any new interventions the I care plan noted for the fall and injury.

13) 11/5/11 at 4:05am on the bathroom floor in the resident room bathroom incontinent of urine--bed and chair alarms were not sounding.--Interventions added 15 minute checks, address the 3 p's (this is not explained) offer early morning activities, staff to check that alarms are on. -- This fall and interventions were not noted on the care plan.

14) 11/6/11 at 3:50pm on the floor in room by the bathroom with alarms sounding--The new interventions indicated resident education on call

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light use--The incident report questions a possible Urinary Tract Infection and Urinary Analysis, no lab records for this could by found in the resident record--No new interventions were noted on the incident report or on the Fall interventions in theCare Plan.

15) 11/8/11 at 10:10pm on hands and knees with forehead on the floor, beside the bed with alarm sounding-- The new interventions noted on the report -- Neuro checks, staff education, 15 minute checks continued, Ambulate to and from dining hall daily. Placed in wheelchair at the nurses station, to be monitored for getting out of bed, address the 3 P's, and to increase Celexa. (Celexa ordered 20 mg on 11/8/11). The investigation found the resident indicated "putting on shoes"this was not addressed on the report .--These interventions and fall were not noted on the Care Plan.

16) 11/10/11 at 9:00am sitting on the bedroom floor--bed alarm not sounding and in the "off" position per the nurses note on the incident report. The resident stated at the time "I just want to sleep"--Interventions on report :continue 15 checks, 3P's, staff to provide activities to decrease restlessness, alarms to bed checked with 15 checks, Staff educated to keep alarms on.-- This fall and interventions were not on the Fall interventions in the care plan.

17) 11/15/11 at 5:45pm at the nurses station -- observed to be getting up from the wheelchair and tangled feet in the wheelchair-- The report states R9 had no staff assistance, and the chair alarm was not sounding. The new interventions noted distraction, ambulate with the resident and

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F9999	Continued From page 41 15minute checks -- the Fall and interventions were not on the Fall interventions in thecare plan. 18) 11/16/11 at 3:15pm in the dining room on the floor beside the wheelchair-- alarm sounding.--The new intervention was Staff offer distraction at change of shift. The fall and interventions were not on the Fall interventions in the care plan. 19) 11/19/11 at 11:15am in the resident room at the bedside, resident calling out.-- The resident is noted to have stated "needed to go to the toilet" The resident complained of left wrist pain---resident sent to ER and returned with diagnosis of fractured left wrist . The incident report indicated that the bed alarm was in the "off" position when evaluated by the nurse. Interview with E17 Licensed Practical Nurse (LPN) on 3/7/11 at 1:00pm confirmed that she had filled out the 11/19/11 incident report for and she had found R9's alarms in the off position. New interventions added : 15 minute checks, when up in wheelchair, to remain in sight of staff-Assess 3p's. These interventions and fall were not on the Fall interventions in the care plan for R9. 20) 11/23/11 at 11:30am in the resident room at the bedside by a housekeeper. The alarms were not sounding and in the off position.-- The new intervention was to keep the alarms on-- The fall and intervention was not on the Care plan. 21) 11/27/11 at 12:30 am beside the bed in the residents room -- the new intervention added a lap alarm, 15 minute checks for 30 days , potty resident at bedtime. The fall and interventions	F9999		

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F9999	Continued From page 42 are not on the Fall interventions in the care plan. 22) 11/28/11 at 3:45am found on the floor at the bedside in the residents room-- the resident was noted with a hematoma on the right side of the forehead-- the under bed mat was moved out of way and the underbed alarm was not sounding when resident found. The interventions included: check if alarm is functioning, and check resident every 15minutes, possible Urinary Tract Infection (UTI), get consent for lap alarm. The interventions and fall were not noted on the Fall care plan. Review of R9's laboratory results found no testing for the possible UTI -- The fall and interventions were not on the Fall interventions in the care plan. 23) 12/3/11 at 6:40am found resident on the floor next to the bed.-- The intervention noted was for the night shift to get R9 up and dressed . The fall and intervention was not on the care plan. 24) 12/12/11 at 2:00am found the resident on the floor next to the bed-- The intervention was a possible UTI The fall and intervention were not on the Fall interventions in the care plan. 25) 1/14/12 at 3:10pm in the resident bathroom on the floor yelling for help-- The intervention was to check the alarm every 30 minutes. The fall and intervention were not on the Fall interventions in the care plan. 26) 1/21/12 at 6:50pm on the floor in front of the commode--The new intervention was not to leave the resident alone on the bathroom -- The fall and intervention were not on the Fall interventions in the care plan.	F9999		

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F9999	Continued From page 43 27) 2/13/12 at 6:45am in the doorway of the Wesley I sitting room, staff observed R9 to fall and receive a 2 inch hematoma. New intervention to ambulate resident. The intervention and fall are not on the Fall interventions in the care plan. 28) 2/24/12 at 2:05pm resident lowered to the floor by staff-- Intervention was 15 minute checks times 3 days. The fall and intervention were not on the Fall interventions in the care plan. Interview with E2 (Director of Nursing) on 3/7/12 at 3:30pm found that the facility is aware of R9's history of falls and E2 indicated that many interventions had been attempted but R9 has continued to fall. E2 indicated that many employee changes have occurred in the Risk Manager position recently. 2. The March Physician's Order sheet for R4 has the diagnoses of a history of a Left hip fracture on 1/11/11 and a Right Hip Gamma Nail on 2/11/12. The review of the incident/accident reports for R4 are as follows: 1/14/12 fall, walking lost balance and fell into chair -- intervention 30 minute checks for 2 days.: 2/7/12 fall, sitting on floor in her bedroom - bumped knees and hit lip on bedframe -- intervention from the incident report was 15 minute checks. The 2/7/12 incident report stated R4 was unsteady ambulating. The 2/11/12 incident report states R4 was found in the floor. The nurses notes dated 2/11/12, 9:00pm indicates R4 was complaining about right hip pain. The nurses notes from regarding the pain stated R4 was sent to the local hospital for an	F9999		

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x-ray. The results were a fractured right hip. The plan of care dated 1/3/12, did not have any interventions for R4's falls. The fall assessment dated 1/3/12 evaluates R4 to be at high risk for falls. The Quarterly Minimum Data Set dated 1/3/12 evaluates R12 to be independent in transfers and ambulation.

3. The physician's order sheet for R3 dated 3/2012 has the following diagnoses, Altered Mental State, History of two Cerebral Vascular Accidents with left Hemiplegia, Renal Failure, Right below knee amputation and Insulin Dependent Diabetes. Per the physician's order sheet R3 was admitted to the facility on 10/6/11. The 11/3/12 and 2/24/12 fall risk assessment evaluates R3 to be at high risk for falling.
The following are falls as indicated on the accident and incident logs for October 2011, November 2011, December 2011, and January 2012, and March 2012.

10/26/11 11:45am transfer self fall no injury under bed alarm implemented and 15 min checks
10/10/11 9:10pm transfer self fall received skin tear 30 minute checks
10/9/11 6:50pm transfer self over side rail to wheel chair no injury 30 minute checks implemented
10/9/11 6:10pm Slid out of bed new intervention two assist for all transfers
11/19/11 2:30 pm slid from wheel chair old scab torn off left elbow intervention 15 minute checks.
11/11/11 10:55am abrasion to left lower leg due to leaning forward intervention 15 minute checks.
11/10/11 11:40am attempting to put self to

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bed alarm was not sounding intervention 15 minute checks and alarm replaced.

11/4/11 3:10pm trying to transfer self, fell to floor in front of wheel chair. no injuries 15 min checks

12/8/11 10:45am slide out of wheel chair to floor no injury, Intervention 15 minute checks, distract from water fountain. Mouth swabs.

12/24/11 11:55pm went over siderails body alarm malfunctioned no injury. Intervention started l/2 rails.

3/8/12 3:45pm Certified Nursing Assistant lowered R3 to the floor while putting on Personal Protective Equipment. No injury.

3/8/12 5:10pm sitting on floor beside bed. New intervention of full padded siderails.

The Minimum Data Set dated 11/3/11 and 2/24/12 evaluates R3 to require extensive to total assistance with all activities of daily living.

4. Review of the facility's Accident log for R10 indicates 8 falls since admission on 5-11-11, according to the admission face sheet. A) The first incident report was noted on 8-31-11 at 4:10PM when R10 fell attempting to exit the bed. A clip personal alarm was sounding. No injury was noted. The report notes R10 was confused and ambulatory with assistance. The facility's Risk Management Root Cause Analysis (RMRCA) form completed for this fall indicates the resident was attempting to get out of bed without assistance. The analysis fails to assess the reason why R10 was wanting to get out of bed. A new intervention of a floor pad x1 at bedside was implemented.

B) The second incident report was noted on 9-20-11 at 3PM when R10 fell from the wheel

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chair in the television room. A clip personal alarm was sounding. R10 sustained pain in her left knee and a 2cm red area. The report notes R10 was confused and ambulatory. (A few steps with help.) The RMRCA form notes a new intervention of 15 minute checks. The purpose of the 15 minute checks was not addressed and the results of the findings was not utilized to implement a plan to try and prevent future falling of this type.

C) The third incident report was noted on 9-28-11 at 12:20 AM when she fell exiting her bed. The clip personal alarm was noted as sounding. R10 sustained a skin tear on her right elbow, left wrist and a hematoma on her forehead. A Computerized Tomography Scan of the head was ordered. Safety measures noted in use was a clip personal alarm, 30 minute checks, call light in reach, and mat on the floor beside bed. The report notes a Certified Nursing Assistant (CNA) had toileted R10 at 12:10AM and returned her to bed. R10 was getting up again to go back to the bath room. The report also notes R10 has a history of removing the clip alarm on her own and in this case the resident was carrying the alarm with them. The RMRCA notes new intervention of an under bed alarm, and an under chair alarm.

D) The fourth incident report was noted on 10-2-11 at 8:45PM when R10 attempted to get up from her wheel chair and fell on her back. R10 was folding wash cloths at the nurses station. The personal alarm sounded. No injury was noted. The RMRCA notes new intervention was continue 15 minute checks.

E) The fifth incident report was noted on 10-26-11 at 7:15AM when she was found sitting on the floor in front of her wheel chair in the hall way by the CNA table. The under chair alarm

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sounded. No injury was noted. The RMRCA notes new intervention was to address "3 P's" with 15 minute checks. (The 3 P's were not defined and there was no explanation how they were to be implemented or monitored.)

F) The sixth incident report was noted on 12-21-11 at 3:45PM when R10 stumbled and fell while walking toward the nurse at the medication cart on the Alzheimer's unit. (R10 was transferred off the Alzheimer's Unit due to Pneumonia on 8-6-11 and returned 11-8-11.) R10 was no longer in a wheel chair for the facility policy indicates the resident must be ambulatory to reside on the Alzheimer's Unit. The Physical Therapy discharge note dated 12-19-11 indicates R10 is ambulatory 10 to 150 feet with stand by assistance, no assistive device and with verbal cues to increase step length. R10 sustained a laceration near the right eye and a skin tear on her right elbow and was sent to the emergency room for an evaluation. Safety measures noted in use were non skid shoes and 30 minute checks. A RMRCA was not completed. New interventions noted on the incident report were neuro checks per policy, 15 minutes checks for 5 days, and staff to assist with ambulation with gait belt for 5 days.

G) The seventh incident report was noted on 1-13-12 at 6:30PM when she fell while ambulating in the television room on the Alzheimer's Unit. R10 sustained a laceration near her right eye and bruising of her right hip and thigh. R10 was sent to the emergency room for an evaluation. The laceration was sutured. The RMRCA was completed and new intervention implemented was noted to be neuro checks per policy and 15 minute checks for 5 days. (The interventions listed fail to address how they will prevent future

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falling of this type.)

H) The eighth incident report ws noted on 1-30-12 at 7:42AM when R10 fell in the dining room next to her chair after missing the chair when she sat down. A red area was sustained on her buttock. The RMRCA was completed and new intervention implemented was noted to be 15 minute checks for three days and resume 30 minute checks. (The interventions listed fail to address how they will try to prevent future falls of this type.)

The current physician's plan of care dated March 2012 indicates diagnoses including Parkinson's Disease and Alzheimer's Dementia. Medications administered include Oxapen, Risperdal, Warfarin, Furosemide, Coreg and Sinemet.

The facility's failure to thoroughly investigate R10's falls and implement effective fall interventions was discussed with E1, (Administrator) at 4PM on 3-12-12.

5. Review of the facility's Accident Log for R11 indicates two falls in the past four months. The admission sheet in the medical record notes an admission date of 6-15-10 and a 11-8-11 diagnosis of a fractured right hip. A) The first fall report is dated 11-2-11 at 9:10PM when R11 reached for toilet tissue and slid off the toilet and landed on the bath room floor. A fractured right hip was sustained. The RMRCA form section addressing new interventions implemented was completed noting: current safety devices as chair alarm, non skid flooring, and 30 minute checks. The resident will be placed on 15 minute checks when returns from the hospital. Environmental assessment completed. The need for a closer toilet tissue holder was identified as well as the

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need to fit resident for new toilet seat extender. The ability for R11 to toilet self unsupervised was not addressed.

E5, (Nurse), stated in an interview at 9:35AM on 3-14-12, R11 now uses a bed side commode for it is easier for staff to place her on this type of commode because she utilizes a stand up lift for transfers.

B) The second fall report is dated 1-14-12 at 9:20PM when she fell trying to transfer self from her wheel chair to the bed. No injury was sustained. A personal chair alarm was sounding. The new intervention noted was 15 minute checks for 3 days, educate to use the call light, call light in reach., and resume 30 minute checks. The results of the 15 or 30 minute checks were not evaluated or addressed to indicate how the results were to be utilized to keep R11 safe from falling.

The failure of staff to evaluate why R11 chose to transfer herself on 1-14-12 was discussed with E1 at 4PM on 3-12-12. R11's most recent Minimum Data Set completed on 2-23-12 notes no cognition impairment, non ambulatory, two person extensive assistance with transfers and wheel chair bound.

On 3-13-12 at 9:40AM, R11 was observed in her room unsupervised on a bed side commode. The facility's Assessment for Accident Risk last completed 12-4-11 notes a score of 14 out of 21. (If over 8, resident is at risk of falling.) The form identifies R11 with poor balance sitting or standing.

On 3-14-12 at 9:30AM, R11 was observed in bed unable to reach her call light for it was attached to a pillow on the floor. At this observation, R11 was confused with delusions. E5 indicated Cipro was started yesterday for an

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abnormal urinalysis and that was a possible cause for the increased confusion.

The current physician's plan of care dated March 2012 indicates diagnoses including Parkinson's Disease and Alzheimer's Dementia. Medications administered include Xanax and Sinemet.

The Comprehensive Plans of Care in the care plan book for R10 (dated 1-31-12) and for R11 (dated 2-23-12) note at risk for falls with a history of falls. The approaches fail to identify medication side effects relative to fall risk, or appropriate interventions to try and prevent future falls based on a thorough and accurate investigation of their falls.

E10, (Licensed Practical Nurse, LPN), stated during an interview at 12:45PM on 3-8-12, she was in charge of risk management for 2 1/2 years. In May 2011, E3, (LPN), took over the position. Recently E6, (Registered Nurse), was asked to take the position since they were a Registered Nurse. E3 stated at 1:05PM on 3-8-12, E6 took over risk management from her on October 3, 2011. E3 noted E6 has been in that position until a couple of weeks ago when she went on a leave of absence. At this time, E10 was placed back in charge of risk management. E1, (Administrator), and E2, (Director of Nursing), concurred at 3:30PM on 3-8-12, the changes in the the risk management position has caused problems in the facility's ability to thoroughly investigate accidents and incidents an plan effective interventions.

6. A review of the facility's Accident Logs dated October 1, 2011 through March 13, 2012 notes

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R13 has fallen 19 times since admission on 09/27/11. Of the 19 falls, there was one injury on 01/05/12 which resulted in abrasions to the right and left buttocks and the left knee. The Physician's orders sheet dated March, 2012 state R13 has a diagnosis of Parkinson's Disease and Mixed Dementia. The Medical Data Set (MDS) dated 10/09/11 states R13's Brief Interview for Mental Status (BIMS) score is a dash (-). E4, (Social Service Director) stated on 03/13/12 at 1:55PM this means R13 was unable to answer any of the questions. The MDS dated 01/09/12 states R13's BIMS score is a 5. (00-15 is the cumulative total for this interview with 15 meaning all questions were answered correctly) The Assessment for Accident Risk dated 09/27/11, 12/11/11, and 02/09/11 each state that R13 is at a risk of falling with scores of 21-22. The assessment states that, "If the score over 8, Resident has a risk of falling."

The Accident Logs dated 10/06/11, 10/08/11, and 10/21/11 state R13 fell while up walking behind a wheelchair. The facility failed to assess the risk of ambulation unassisted and the interventions instituted were ineffective in preventing further falls.

The Accident Logs dated 10/03/11, 10/10/11, 10/12/11, 11/05/11, 11/24/11, 11/26/11, 12/07/11, 12/14/11, 12/21/11, 12/31/11, 01/05/12, 01/13/12, 01/23/12, 02/13/12, 03/03/12, and 03/04/12 state these falls were in R13's room. The interventions indicated that the staff should educate R13 on safety and encourage R13 to use the call light. The interventions instituted failed to address the risk of unassisted transfers and the facility failed to provide adequate supervision. The

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interventions did not address R13's reliability to use the call light daily.

7. R13's care plan dated 01/09/12 has "a history of multiple falls" noted as a problem. The care plan is not comprehensive and only indicated 4 of the 19 falls. The current interventions are not updated and or current on the care plan.

A Risk Management Root Cause Analysis was completed after each of the falls. The interventions were not effective in preventing further falls as evidenced by the 19 falls in six months.

8. The Physician's History and Physical (H&P) dated 02/15/12 states R7 has a diagnosis of Dizziness and Vertigo-mild. The Assessment for Accident Risk dated 12/31/11 is scored a 9. The assessment states, "If score over 8, Resident has a risk of falling." The Resident Incident Report dated 02/04/12 states R7 fell on the floor and was found in their room. R7 stated, she got up to go to the restroom, was dizzy, lost balance and fell and hit her head on night stand. The report indicates there was not an injury. The Universal Progress Record and Consultants Reports state R7 complained of intermittent dizziness from 02/04 to 02/17.

R7's Brief Interview For Mental Status (BIMS) dated 12/16/11 is scored a 15. (00-15 is the cumulative total for this interview with 15 meaning all questions were answered correctly) R7's Medical Data Set (MDS) dated 12/16/11 states that R7 is independent with ambulation and all activities of daily living.

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F9999	Continued From page 53 Th Risk Management Root Cause Analysis dated 02/04/12 states the new interventions are for "15 minute checks x 5 days, neuro checks per facility policy, ice pack to head prn (as needed) x 24 hours." There was no intervention added for educating R7 on ways to decrease vertigo and for safety measures with transfers. On 02/15, the Universal Progress Record state R7 complained of hip, coccyx, and neck pain and that R7 felt the pain was in relation to the fall of 02/04/12. The physician was notified and R7 was sent to the local hospital for an x-ray. The physician's H&P dated 02/15 requested a urinalysis to "make sure that is not the cause of her back pain and dizziness" and "it looks like there may be a fracture of the very distal coccyx but that there is not TX (treatment) for this." The Care Plan dated 12/16/11 states that R7 has a history of dizziness and is at risk for falls. The Care Plan is not comprehensive and does not note the recent fall, fracture, or exacerbation of dizziness. (B)	F9999		