

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146019 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 08/28/2012 |
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| NAME OF PROVIDER OR SUPPLIER WABASH CHRISTIAN RETIREMENT | | | STREET ADDRESS, CITY, STATE, ZIP CODE 216 COLLEGE BOULEVARD CARMI, IL 62821 | | |
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| F 323 | Continued From page 20 of 08-10-12. I. The Quality Assurance Committee which includes the Medical Director will review the audits of fall for continued compliance with staff knowledge and competency of protocol until the compliance is maintained as determined by the Quarterly Assurance Committee review. Completion date of 08-09-12 | F 323 | | | |
| F9999 | FINAL OBSERVATIONS Licensure Violations: 300.610a) 300.690a) 300.1210b)5) 300.1210d)3)4)5) 300.1220b)2)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 21 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 300.1210 General Requirements for Nursing and Personal Care 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 | F9999 | | | |

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| F9999 | <p>Continued From page 22</p> <p>transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.</p> <p>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:</p> <p>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</p> <p>4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the</p> | F9999 | | | |

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| F9999 | <p>Continued From page 23</p> <p>nursing services of the facility, including:</p> <p>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.</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> | F9999 | | | |

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| F9999 | <p>Continued From page 24</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to thoroughly investigate the circumstances surrounding falls, develop effective interventions to prevent falls, monitor to ensure that the interventions on the care plan are implemented to prevent falls, provide adequate supervision during periods of unsafe ambulation/change in condition, and evaluate the environment for accident hazards for 3 residents (R3, R5, R8) reviewed for falls.</p> <p>R3, who was assessed as high risk for falls (Fall Risk Evaluation dated 04-13-12), sustained 6 falls from the time period of 05-10-12 through 07-02-12 (Incident/Accident Log). According to R3's Death Certificate dated 07-04-12, the immediate cause of death was Bilateral Subdural Hematomas due to or as a consequence of Head to Face Trauma due to or as a consequence of two Falls.</p> <p>R5, who was assessed as high risk for falls (Fall Risk Evaluation, most recently dated 08-01-12), sustained 6 falls from the time period of 07-18-12 through 08-08-12 (Incident/Accident Log). According to R5's Death Certificate of 08-08-12 R5's death was a result of a fracture of the Femoral Neck and as a consequence caused a Pulmonary Fat Embolism that resulted in Respiratory Arrest and death on 08-08-12.</p> <p>The facility identified on 08-09-12 that 91 of the 137 residents in the facility are assessed as high fall risk.</p> | F9999 | | | |

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| F9999 | <p>Continued From page 25</p> <p>The findings include:</p> <p>1. According to the April, 2012 Physician's Order Sheet, R3 was admitted to the facility on 04-13-12 with diagnoses that includes Seizure Disorder, Dementia, and History of Falls.</p> <p>R3's Minimum Data Sets dated 04-26-12 and 07-02-12 document that R3 had long and short term memory problems.</p> <p>The facility Fall Risk Evaluation for R3 dated 04-13-12 documents that R3 was high risk for falls at time of admit to the facility.</p> <p>The facility incident/accident reports were reviewed for R3 and it was found that she had 6 falls from 05-10-12 to 07-02-12.</p> <p>A. The Incident/Accident Report for a fall on 05-10-12 at 6:45 pm (first fall) documents that R3 was not acting herself and was confused. This report also indicates that R3 was ambulating down the hallway briskly with her walker and fell to the floor, hitting head on the carpeted floor. This report lists the cause as R3's walking too fast with her walker. R3's Care Plan with start date of 04-13-12 lists a new intervention to be implemented of encourage R3 to slow down with wheeled walker. The facility Investigation Conclusion documents that R3 will at times forget to use the walker and is to be checked on frequently to ensure safety and comfort.</p> <p>There is no plan on R3's care plan that addresses how frequent visual checks are to be done nor a plan to address R3's non-use of the walker at</p> | F9999 | | | |

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| F9999 | <p>Continued From page 26 times or walking too quickly.</p> <p>B. The Incident/Accident Report for a fall on 05-10-12 at 7:25 pm (second fall) documents that R3 refused to use a wheel chair to go back to R3's room and took off ambulating without walker and fell face forward to the floor with staff trying to stop the fall. R3 did not sustain an injury according to this report. The Post Fall Investigation for this incident verifies that R3 fell to the floor. R3's Care Plan with start date of 04-13-12 lists a new intervention to request from the physician an order for seizure medication labs. The facility Investigation Conclusion Documents that R3 does ambulate with a walker, sometimes she forgets to use the walker, and is checked on frequently to ensure safety.</p> <p>There was no plan initiated that addresses how frequently visual checks are to be done nor a plan to address R3's non-use of the walker at times. Also, there in no plan with interventions on the Care Plan to address using the wheeled walker appropriately.</p> <p>C. The Incident/Accident Report for a fall on 05-11-12 at 10:30 am (third fall) could not be found according to E2, Director of Nurses, on 08-08-12 at 10 am. R3's Nurse's Notes dated 05-11-12 at 10:30 am document that R3 was ambulating down the hallway without her walker and fell face forward scraping the bridge of her nose on the carpet. R3's Care Plan with start date of 04-13-12 lists a new intervention to notify family for different slippers. The facility Investigation Conclusion for this incident documents that R3 was ambulating down the hallway without her walker, lost her balance, was</p> | F9999 | | | |

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| F9999 | <p>Continued From page 27</p> <p>assessed and found to have a scrape on R3's nose. This form also states R3 forgets walker at times, has been more confused lately, slippers were loose and did not fit well which could be hazardous (replace slippers), and is checked on frequently to ensure safety and comfort.</p> <p>R3's care plan dated 04-13-12 has an original approach for a problem of potential for falls that states to "Make sure resident has proper fitting shoes with laces tied or skid free slippers on before all transfers or ambulation." There was no plan initiated that addresses how frequently visual checks are to be done nor a plan to ensure that R3 used her walker at all times.</p> <p>D. The Incident/Accident Report for a fall on 06-17-12 at 9:10 am (fourth fall) documents that R3 was ambulating with her walker between an electric lift recliner and the wall, tripped on the power cord, falling face first to the floor. According to the nurse's notes dated 06-17-12 at 9:10 am, R3 did not respond when name was said and was having a seizure which lasted 5 minutes. The nursing notes state R3 sustained an abrasion to the right eyebrow with bruising and swelling already present to the right side of her face. R3's Nursing Notes dated 06-17-12 at 9:10 am document that R3 tripped over a power cord for a lift chair in the back lobby. The facility Investigation Conclusion documents that pressure was applied to the abrasion of the left eye until bleeding stopped, R3 alert within 5 minutes after seizure but feeling tired. This Investigation Conclusion also states R3 and Z4, R3's Power of Attorney, refused to go to the emergency room and Z1, physician, ordered an x-ray of the right cheek bone/face.</p> | F9999 | | | |

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| F9999 | Continued From page 28 R3's Care Plan dated 04-13-12 has an original approach for falls to "Keep pathway clutter free. Monitor environment for wet spots or items placed below field of vision on the floor." This approach was not followed due to the power cord of a lift chair being stretched across the open space between the chair and the wall. No plan with interventions to increase supervision was implemented to prevent further falls. E. The Incident/Accident Report for a fall on 06-17-12 at 6:20 pm (fifth fall) documents that R3 was confused when R3 was found in the bathroom floor on her right side with a skin tear to the left forearm and right elbow and that R3 was taken to the hospital. R3's Nurse's Notes of 06-17-12 at 6:20 pm document R3 was found on the bathroom floor incontinent of bowel, had emesis on her clothing, and had increased confusion. This notes state R3 was transported to the hospital. A Nurse's Note for R3 dated 06-18-12 at 2:15 am documents R3 was admitted with Bilateral Subdural Hematomas. The facility Investigation Conclusion form documents that family did not want the neurosurgeon to attempt a craniotomy and R3 was sent back to the nursing home for comfort care. The plan of action to prevent reoccurrence on the Investigation Conclusion states, "Continue risk vs benefits analysis, resident's independence in ambulation and her overall independence were of high importance to her. Attempting to have her SBA (stand by assist) or assist of 1 caused her increased anxiety, stress and increased behaviors. Res. (resident) and fmly (family) were aware of likelihood of continued falls with injuries | F9999 | | | |

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| F9999 | <p>Continued From page 29 but resident dignity and independence were higher on her list than the risk of fall.</p> <p>There was no plan with interventions initiated that analyzes the falls and addresses increasing supervision to prevent further falls. There was no consideration given to interventions such as need to assist with toileting and increase activities in a setting that is supervised.</p> <p>F. The Incident/Accident Report for a fall on 07-02-12 at 5:15 am (sixth fall) documents R3 fell out of bed and was found curled up in a ball on the floor with a pillow under R3's head. R3 was confused according to this report. The Investigation Conclusion Form for this incident documents R3 had altered safety awareness and declining condition due to Subdural Hematomas. The Investigation Conclusion Form for this incident also stated "Staff did not consider the monitor prior to because it would have been a dignity issue and would have upset her." The Care Plan dated 04-13-12 stated a new approach was started on 07-02-12 of Pressure monitor at all times.</p> <p>Review of R3's Care Plan dated 04-13-12 documents R3 had a problem of potential for falls and/or injury related to history of falls. The approaches listed do not include a plan to increase supervision of R3. E5, Registered Nurse - Care Plan Coordinator, stated during an interview on 08-09-12 at 10:40 am that the undated approaches are the original approaches at the time of the original Care Plan and after each fall the fall date is then added to the Care Plan with an approach also added. The first 7</p> | F9999 | | | |

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| F9999 | <p>Continued From page 30</p> <p>approaches on R3's Care Plan are not individualized and are the same approaches found on the care plans of R5, and R8.</p> <p>Review of the Incident/Accident Reports and the Post Fall Investigations of R3's falls document that areas were not completed on the forms. On R3's 05-10-12 Post Fall Investigation form the transfer assistance was not completed On the 06-17-12 at 6:20 pm Incident/Accident Report does not list the immediate intervention implemented to prevent re-occurrence and the Post Fall investigation of this incident does not indicate transfer assistance and ambulation assistance required. On the 07-02-12 at 5:15 am Post Fall Investigation form, the transfer assistance and the ambulation assistance required was not completed.</p> <p>Z1, Physician, was interviewed on 08-09-12 at 11:25 am. Z1 stated that he was notified of R3's falls on 06-17-12 and said that R3's level of cognitive ability was not regained after the falls on 06-17-12. He also verified that R3 had Alzheimer's Disease. Z1 also stated that he agreed with the cause of death on the Death Certificate.</p> <p>The Certification of Death Record for R3 documents date of death as 07-04-12 and the cause of death "Bilateral Subdural Hematoma", "Head and Facial Trauma", and Falls times Two". The Description of how the injury occurred is given as "1. Tripped over power cord from lift chair. 2. Found on bathroom floor, reason unknown."</p> | F9999 | | | |

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| F9999 | Continued From page 31 2. The Cover Sheet for R5's Care Plan dated 11-13-11 (completed at the time of the Annual Minimum Data Set and reviewed quarterly) documents that R5 had diagnoses that includes Orthopedic Aftercare, Hypertension, Chronic Airway Obstruction, Ischemic Heart Disease, Type II Diabetes Mellitus, Muscle Weakness, and Senile Dementia. R5's Care Plan documents a problem of at risk for falls with injury related to his diagnoses including history of falls with fractures as well as his medication usage. E5, Registered Nurse - Care Plan Coordinator, stated during an interview on 08-09-12 at 10:40 am that the undated approaches are the original approaches at the time of the original Care Plan and after each fall the fall date is then added to the Care Plan with an approach also added. The first 7 approaches on R3's Care Plan are not individualized and are the same approaches found on the care plans of R5, and R8. Review of R5's Nurse's Notes document increased confusion on 07-14-12 at 11 am and 08-01-12 at 6 pm. Also, the Nurse's Notes dated 07-24-12 at 10 am stated R5 is "feeling better but cont (continues) to be weak. will monitor." According to the facility Fall Risk Assessment, R5 was assessed as high risk for falls on 02-24-12, 07-25-12, 07-27-12, and 08-01-12. The facility incident/accident reports were reviewed for R5 and it was found that he had 6 falls from 07-18-12 to 08-07-12. Review of the Incident/Accident Reports and the Post Fall | F9999 | | | |

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| F9999 | <p>Continued From page 32</p> <p>Investigations of R5's falls document that areas were not completed on the forms. On R5's 07-20-12 Post Fall Investigation form the area addressing transfer assistance and ambulation assistance were not completed.</p> <p>A. The Incident/Accident Report for a fall on 07-18-12 at 4:45 pm (first fall) documents that R5 was ambulating with a walker in his room to the bathroom to change clothes and fell on his buttocks near the end of his bed at which time he sustained a hematoma to the back of the head. R5 stated after the incident that he felt weak recently. The cause of the incident was listed on this report as slipped walking in sock feet. R5's Nurses's Notes dated 07-18-12 at 4:45 pm state that therapy is to screen R5 due to increased weakness and gait is unsteady. A new intervention was added to Care Plan dated 11-25-11 to refer to skilled therapy. The facility Investigation Conclusion Form documents that R5 has a slow gait and is unsteady at times. Also this form states R5 is checked on frequently to ensure safety and comfort.</p> <p>Review of R5's Care Plan of 11-25-11 does not include a plan with interventions to provide frequent checks for R5 and supervision when unsteady. Also, the facility did not follow R5's Care Plan approaches by allowing R5 to wear regular socks instead of wearing shoes or nonskid socks to prevent slipping while walking.</p> <p>B. The Incident/Accident Report for a fall on 07-20-12 at 5:30 am (second fall) documents that R5 was found by staff sitting in the floor on his bottom next to his bed. R5 stated he was trying to put his clothes on. The immediate intervention</p> | F9999 | | | |

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| F9999 | <p>Continued From page 33</p> <p>implemented according to this report was to place appliques beside R5's bed and educate R5 to wear shoes, use call light and ask for help.</p> <p>Review of R5's Care Plan of 11-25-11 does not include a plan with interventions to provide frequent checks for R5. There is no mention in the incident information that the 07-18-12 fall information was taken into consideration and used in the analysis of the falls and used to develop a plan for increased supervision during times when R5 would be changing clothes. The facility did not follow R5's Care Plan of 11-25-11. R5's Care Plan does include an intervention to "Make sure resident has proper fitting shoes with laces tied or skid free slippers on before all transfers or ambulation."</p> <p>C. The Incident/Accident Report for a fall on 07-25-12 at 11:15 am (third fall) documents that R5 was attempting to get up off the edge of the bed and his foot slid causing him to fall face forward resulting in a knot on R5's forehead and a skin tear to the right ear. R5's Care Plan dated 11-25-11 had a new intervention added on 07-25-12 to encourage R5 to keep door open.</p> <p>Review of R5's Care Plan of 12-13-11 does not include a plan with interventions to provide frequent checks for R5. There is no mention in the incident information that the facility looked at the previous falls and used the information to develop a plan with interventions for increased supervision and R5's increasing weakness.</p> <p>D. The Incident/Accident Report for a fall on 07-27-12 at 12:30 am (fourth fall) documents that R5 was observed laying on the edge of the bed</p> | F9999 | | | |

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| F9999 | <p>Continued From page 34</p> <p>and was observed to roll out of bed onto the floor on his right side. The immediate intervention listed on this report was to replace the old nonskid socks with new ones and educate R5 to use his call light if he needs assistance. The Post Fall Investigation documents that R5 is a one person transfer and needs assistance with ambulation. R5's Nurse's Notes of 07-27-12 documents after this fall R5 had "gait slow - unsteady - shuffles - slumps - speech slow - slurred".</p> <p>Review of R5's Care Plan of 11-25-11 does not include a plan with interventions to provide frequent checks for R5. There is no mention in the incident information that the facility looked at the previous falls and used the information to develop a plan with interventions for increase supervision and R5's increasing weakness with declining condition.</p> <p>E. The Incident/Accident Report for a fall on 08-01-12 at 8:20 pm (fifth fall) documents that R5 fell out of bed onto right hip with no injury. The facility Post fall investigation of that date documents that R5 was again sleeping on the edge of the bed and is a one person assist for transfer and ambulation. The new intervention to be implemented on R5's Care Plan of 11-25-11 was a concave mattress.</p> <p>Review of R5's Care Plan of 12-13-11 does not include a plan with interventions to provide frequent checks for R5. There is no mention in the incident information that the facility looked at the previous falls and increasing confusion .to develop a plan with interventions for increased supervision nor did they consider looking at</p> | F9999 | | | |

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| F9999 | <p>Continued From page 35</p> <p>toileting schedules, sleep schedules, and need for increased activities for R5.</p> <p>F. The Incident/Accident Report for a fall on 08-07-12 at 2 pm (sixth fall) documents R5 was heard yelling and was found in his bathroom on floor in front of the toilet. R5 was assessed and found to have external rotation of the left leg and R5 complained of extreme pain and was placed on a back board with left leg and hip stabilized with pillows. R5's Nurses Notes dated 08-07-12 at 2 pm document R5 was found on the bathroom floor complaining of severe left hip pain and was transported to the emergency room.</p> <p>Review of R5's Nurse's Notes for 08-08-12 at 4 am documents that the hospital called to inform the facility that R5 had expired.</p> <p>The Certificate of Death record for R5 documents date of death as 08-08-12 and the cause of death "Respiratory Arrest", with sequential conditions leading to the cause as "Fall, Femoral Neck Fracture, and Pulmonary Fat Embolism". The Certificate of Death lists the date of the injury as 08-07-12 at 2:30 pm. The description of how the injury occurred is given as "Fall".</p> <p>Z2, R5's Physician, was interviewed on 08-23-12 at 4:35pm and stated that he was informed of R5's falls and his decline in physical condition. Z2 stated that R5 had gradual weakness and failure to thrive. Also, Z2 said it was possible for the Femoral Neck Fracture to have caused the Pulmonary Fat Embolism and R5's death.</p> <p>3. R8 is a 72 year old resident with a diagnosis of</p> | F9999 | | | |

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| F9999 | <p>Continued From page 36</p> <p>Dementia who was admitted to the facility on 7-7-2012 from the hospital, after a fall at home that resulted in a fracture to the right hip. This information was obtained from review of the Hospital Discharge Summary dated 7-7-2012. On admit, the facility assessed R8 as high risk for falls as noted on the Fall Risk Evaluation dated 7-7-2012. R8's initial Minimum Data Set dated 7-14-2012 assessed R8 as needing extensive assist with bed and transfer mobility as well as toileting. Balance was assessed as being not steady and only able to stabilize with staff assist.</p> <p>A. Review of the nurses notes and the Facility Incident/Accident Report both dated 7-9-2012 noted that R8 had a fall with no injury on 7-9-2012 at 4:45 am in her room. This fall was witnessed by a Certified Nurse Aide who was entering the room at the time. R8 had been seen 15 minutes before the fall transferring herself to the bed side commode. The report indicates that R8 was reminded that she was to call for assistance because she had a fractured hip, with R8 replying to staff that she was not "here" for them to take care of her and that she could do what she wanted. R8, according to the report, did not recall that she had recently fractured her right hip and a mobility monitor was put in place at that time. R8 was diagnosed with a Urinary Tract Infection (UTI) on 7-9-2012 and began treatment with an antibiotic according to the 07-09-12 Nursing Notes. The current care plan (with a run date of 8-8-2012) does not include an individualized plan with interventions to provide supervision to prevent R8 from attempting self transferring.</p> <p>B. A second fall occurred on 7-18-2012 at 1:15</p> | F9999 | | | |

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| F9999 | <p>Continued From page 37</p> <p>am in her room as noted by review of the Facility Incident/Accident report dated 7-18-2012. The Incident Report indicates that R8 had been agitated all night and had increased confusion. The report also notes that R8 had been sitting at the nurses station in a wheel chair 10 minutes prior to the fall but had wheeled herself down to her room. It indicates that R8's mobility alarm was sounding at the time she was found. R8 sustained a skin tear to the right arm. The same care plan dated above had an approach added on 7-18-2012 to contact the physician for a follow up urinalysis because of signs and symptoms (of continuing urinary tract infection). No other approaches are noted after this second fall such as increased monitoring schedule, increased toileting or increasing fluid intake to assist in treatment of the urinary tract infection.</p> <p>E1, Administrator, stated per interview on 8-22-2012 at 4:30 pm that any approaches added after the second fall are noted on the care plan (as noted above). Review of R8's Care Plan document that no other approaches were attempted.</p> <p>C. R8's third fall occurred on 7-22-2012 at 5:45 pm in R8's room as noted by review of the Facility Incident/Accident report dated 7-22-2012. It indicates that R8 had disconnected her mobility alarm and stated that she just wanted to get up and walk around her room. According to the report, R8 had last been observed eating supper 5 minutes earlier. R8's Nursing Notes for 07-22-12 at 5:45 pm document that R8 complained of pain to her left hip and a skin tear of her left arm was noted. R8's x-ray report dated 7-22-2012 indicated that the x-ray was normal.</p> | F9999 | | | |

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| F9999 | <p>Continued From page 38</p> <p>The mobility alarm was discontinued and a pressure alarm was implemented at all times on 07-22-12 according to R8's Care Plan.</p> <p>On 7-24-2012 the nurses notes indicate that R8 was continuing to complain of left hip pain and soreness and a pelvic x-ray was ordered and indicated a possible left hip fracture. Ultimately, a Computerized Topography (CT) scan was performed on 7-26-2012 and an acute fracture of the left femoral neck was noted according to R8's CT report.</p> <p>There is no indication that the facility took into account R8's first two falls occurred in her room and used the information to implement additional approaches on the Care Plan to address the issue, resulting in R8's third fall and another fractured hip.</p> <p>(A)</p> | F9999 | | | |