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F 469	Continued From page 61 E25 (Environmental Director) said on 5/6/13 at 11:05 AM, that the contracted Pest Control company comes 2 X a month. Review of the Pest Control Report indicated the facility was treated for ants infestation on 4/26/13.	F 469		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.1210d)5) 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. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	F9999		

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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.

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:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as

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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. (Section 2-107 of the Act)

THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:

Based on observation, interview and record review, the facility failed to consistently monitor, comprehensively assess, identify and follow plan of care to prevent the development of facility acquired pressure ulcers.

This applies to 2 of 4 residents (R10 and R11) reviewed for pressure sores in the sample of 18.

As a result of this failure, R10 developed stage II pressure sore which became unstageable in 21 days. R11 developed a deep tissue injury related to a pressure on the left hip and a stage 2 pressure sore characterized by a blood filled blister on the left outer ankle and a fluid filled blister on the left forefinger around the knuckle.

Findings include:

1. R10 has diagnoses including Dementia, COPD (Chronic Obstructive Pulmonary Disease)and Alzheimer disease.

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R10 is totally dependent on staff for all ADL (Activities Daily Care) care and is mostly in bed.

Review of Weekly Wound Documentation dated 01/14/13 showed "Nurse notified of open sore to the sacral area. Assessment completed, Stage II noted, measured and documented. Z6 (Physician) notified with new orders received and carried out. Family notified. Dietary notified of new pressure sore ulcer awaiting recommendation."

The facility's initial wound assessment on 01/14/13 described the wound as L (length) 1.2 cm x W (Width) 1.2 cm x D (Depth) 0.1 cm, stage II, superficial wound bed, surrounding area intact and with scanty drainage.
On 05/08/13 at 11 AM E3 (Nurse Consultant) acknowledged that the documentation for weekly wound assessment for R10's for January 22 and January 29, 2013 were missing. E3 further stated that there was no documentation to show that the wound was unavoidable.
The facility did not initiate care plan when R10 developed stage II pressure on 01/14/13.

On 02/04/13, the Skin Alteration Record described the sacral wound as bigger with the measurement as L-2. 2 cm x W- 2 cm D- 0.2 cm unstageable, 100 percent slough.
The wound was described as Necrotic-eschar, black in wound 100 %.
Wound care evaluation by the Wound Doctor on 02/04/13 also described the sacral wound as L-2cm x W- 2 cm with 0.2 depth unstageable, Eschar/necrosis 100 percent with minimal serous exudate.

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Treatment order for the pressure sore on 01/14/13 " Cleanse sacral with NSS (Normal Saline Solution), apply collagen dressing, cover with Duoderm. Change QOD (every other day) and PRN (as needed) until healed. On 02/04/13 the treatment order was changed to apply Santyl & Bacitracin ointment and cover with foam dressing and PRN.

March TAR (Treatment Assessment Record) showed that the box was left blank on March 30 and 31, 2013 meaning treatment on the sacral area were not done.

R10's care plan for pressure sore was initiated on 02/4/13 when the pressure sore was already unstageable.

On 05/07/13 at 1 PM, E28 (wound nurse) indicated that she was new in the facility and did not know how the pressure sore developed.

2) R11 has diagnoses which include Parkinson's Disease, Dementia, COPD (Chronic Obstructive Pulmonary Disease) and mild mental retardation. R11 was an 82 year old with original admission to the facility on 7/5/2006. R11 had been hospitalized on 4/8/2013 and readmitted back to facility on 4/18/2013.

Review of latest MDS (Minimum Data Set) dated 4/25/2013 showed that R11 scored 7= severely impaired for BIMS (Brief Interview for mental Status). R11 also required total assistance for hygiene and bed mobility with 1 person physical assist.

Review of "Wound Care Evaluation" dated

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4/29/2013 showed that R11 had multiple wounds due to multiple risk factors for skin breakdown. This evaluation also included that R11 be turned and repositioned in bed every 1-2 hours and be checked for skin breakdown daily.

During wound dressing change observation on 5/6/2013 at 11:15 A.M. with E16 (Wound Treatment Nurse) and E18 (Restorative Aide), R11 was in bed, alert and responsive. R11 was partially turned to his left side and left buttock was touching the bed . There was a sensor alarm pad made of vinyl plastic that was placed directly underneath R11's buttocks. There was a bed sheet in between the vinyl sensor pad and R11's buttocks. E16 informed E18 that R11's plastic vinyl sensor pad should not be placed directly underneath the sacral /buttocks/ ischium area as this could cause more pressure/friction to the existing pressure sores. R11 was noted with multiple pressure sores on the following areas:
- upper outer area of the right ear around the cartilage
- unstageable pressure sore with eschar on the sacrum
- unstageable pressure sore covered mostly with slough on the left ischium
- stage 2 pressure sore on the right buttock
- unstageable pressure sore with eschar on the scrotum
- unstageable pressure sore with eschar on the right heel
- left hip pressure ulcer, with reddish /purplish discoloration
- stage 2 bloody fluid filled blister on the left outer ankle
- fluid filled blister on the left forefinger around the knuckle

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F9999	Continued From page 67 During this observation, E16 stated that she was not aware of the existence of the pressure sores on the left hip, left ankle and the blister on the left forefinger. E18 stated that she was not aware of the existence of these pressure sores (left hip,left ankle and left forefinger) during the perineal care approximately 30 minutes prior to the dressing change. There were no assessements and treatments to these unidentified sores. Review of current "Ongoing Skin Alteration Record" showed the following wound assessments: - right outer ear with 1.3 cm in length; width 0.3 cm, depth 0.1 with scant exudate acquired at the facility on 5/4/2013 - left ischium with 7.2 cm in length, 7.3 cm in width and 0.3 cm in depth assessed on 4/29/2013 as unstageable pressure sore with eschar with moderate exudate - right buttock stage 2 pressure sore with 2 cm. in length, 1 cm width, and depth of 0.1 cm. - pressure sore on the scrotum with 2 cm. width, 1 cm. length and 0.1 cm in depth, eschar with scanty serous exudate as assessed on 4/29/2013 - unstageable pressure ulcer on the right heel with 4 cm. in length and 3 cm. in width During the initial tour on 5/5/2013 at 12:30 P.M., there was a "Repositioning Schedule" posted above R11's headboard. The repositioning schedule was as follows: -10 A.M. facing window(R11's left side) -12 noon facing door(R11's right side) - 2 P.M., facing window	F9999		

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F9999	Continued From page 68 - 4 P.M., facing door - 6 P.M., facing window R11 was observed in bed on 5/5/2013, lying on his left side facing the window at 12:30 P.M., 2:10 P.M., 4:00 P.M. and 6:15 P.M. On 5/8/2013 at 4:50 P.M., E17(CNA- Certified Nurse Assistant) stated that R11 was supposed to be turned at 12 noon on 5/5/2013. E17 said that she was not able to turn R11 at 12 noon and only repositioned R11 at 1:30 P.M. (facing the window) because E17 was attending other residents during lunch time in the main dining room. This indicated that R11's turning and repositioning schedule was not followed. Review of current plan of care indicated that R11 be turned and repositioned every 1-2 hours for pressure relief. This plan is to prevent development of new pressure sores and worsening of the existing sores. R11's record also showed that there was no current comprehensive nutritional assessment to ensure that optimal nutritional intervention for wound healing was in placed. E3(Nurse Consultant) acknowledged this concern on 5/8/2013 during the daily status meeting. (B) 300.1210b) 300.1210d)3) 300.3240a)	F9999		

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F9999	Continued From page 69 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. 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: 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. 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) THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY: Based on observation, record review and interview, the facility failed to supervise residents,	F9999		

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revise specific interventions to prevent further falls and failed to implement facility's policy for safe transfer. This is for 7 of 8 residents reviewed for falls in the sample of 18 (R3, R4, R6, R8, R11, R14 and R16).

The facility also failed to lock and supervise treatment and respiratory carts. The treatment cart contained multiple medications/ointments and the respiratory cart contained breathing treatment medications.

This failure resulted in R14 sustaining an impacted intertrochanteric basocervical fracture of the proximal left femur with some varus deformity at the fracture site. R14 was sent to the hospital with a diagnosis of left hip fracture.
R11 sustained laceration that required sutures at the hospital due to a fall on 3/20/2013.

Findings include:

1. R14 was admitted to the facility on 09/20/12 with diagnoses including Dementia, Hypertension and Osteoarthritis.

R14 had 8 falls for the period of 4 months from 12/11/13 to 04/12/13.

On 12/11/12 at 1:30 PM, it was documented that R14 was noted sitting on the floor in the TV (Television) lounge next to the chair. R14 attempted to ambulate without staff assistance and tripped over walker causing her to loose balance and she (R14) was showing sign of urinary tract infection.
Per statement of E32 (CNA- Certified Nursing Assistant) and E13 (nurse), R14 was sitting in

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the nurses station. R14 wanted to go to the TV room. R14 was taken to the TV room, assisted to seat in the lounge chair and activated the alarm. CNA was by the nurses' station and the nurse was also at the nursing station charting. When R14's alarm activated the CNA called the nurse attention. R14 tripped in her walker and was found on the floor.

Further review of Accident/Incident report showed that R14 had further multiple falls while in the TV room on the following dates:

-on 01/20/13 at 9:45 AM R14 was again found on the floor in the TV room in front of the wheelchair.

- on 12/23/2012 at 1:50 PM, R14 was sitting in her wheelchair in the hallway and attempted to stand up unassisted from a wheelchair and slid down on the floor.

- on 1/27/2012 at 3:25 AM, the report documented that R14 was sleeping in lobby chair. E31 (Nurse - former employee) who was with R14 left to answer a call light. When finished attending the other resident's needs, E33 CNA informed E31 that R14 was on the floor.

- on 02/03/13 at 9:30 AM, R14 was sitting on wheelchair and attempted to transfer from the wheelchair to the couch and slid to the floor. This happened again in the TV room.

- on 02/16/13 at 6:45 PM, R14 was found in the TV room in upright position, elbow leaning on the floor. R14 stated she thought it's the chair but she ended on the floor.

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On 05/07/13 at 12:20 PM, E16 (Nurse) stated, "I was at the nursing station, R14 was sitting in the couch inside the TV room. I heard the alarm went off and found resident on the floor. R14 was not visible in the TV room and there was no staff present in the TV room when R14 was found on the floor. The resident just had their dinner and the CNA (former employee) said she just transferred R14 from the wheelchair to the couch. The 2 other CNAs were in the dining room to bring residents back to the unit."

- on 03/21/13 at 6:30 AM, R14 was found on the floor in the TV room, staff observed R14 trying to get out of her reclining chair and was about to fall. Staff caught her and assisted her down to the floor.

- on 4/12/13 at 4:50 AM, R14 was sleeping in the recliner chair in the TV room. CNA left R14 to take a break and left the R14 unsupervised. Alarm was heard and R14 was discovered on the floor.

The Nurse's notes dated 04/12/13 at 4:40 AM documented that R14 was assessed immediately showing left hip/femur pain. Ice placed on the area and Tylenol 650 mg was given. There was no documented ROM (Range of Motion) assessment. Despite her complaint of pain and without checking her ROM, R14 was assisted to the washroom at 5:15 AM.
At 6:15 AM, the physician was notified and stat Left femur/hip X-ray was ordered to rule out fracture.

There were no nursing documentation of R14's

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condition until 4:00 PM which showed that R14 was awake and sitting up in the wheelchair. R14 complained of left hip/leg pain upon movement.

The Stat X ray was not done until 3:30 PM. Norco 5/325 mg was given for pain. This indicated that R14 was in pain but facility staff continued to move R14, assisted her to the bathroom and got her up in the wheelchair.

X ray report dated 4/12/13 showed an impacted intertrochanteric and basocervical fracture of the proximal femur with some deformity at the fracture site. R14 was sent to the hospital.

During telephone interview on 05/08/13 at 1:25 PM, E40 (CNA) stated, "I was sitting with R14 in the TV room. R14 was sitting on the couch. I went out to the nursing station to tell my nurse that I am going on my break. The nurse said okay. I went outside of the building to smoke cigarette for about 5- 10 minutes. When I came back, R14 was already on the floor. I am the only CNA on that floor and there was a nurse and 1 nurse orientee. The nurse knows that I was watching R14. I am usually with her when R14 is up. I try not to leave R14 because I don't want R14 to have a fall."

The facility was aware that R14 had fall episodes when unsupervised and often when placed in the TV room. Care plan addressed the falls with the same approaches that have not worked as R14 continued to fall when not supervised. The facility continued to leave R14 unsupervised which resulted to more fall incidents and injury to R14 including a hip fracture and a visit to the Emergency room. The facility failed to provide

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proper handling of R14 as they transferred her to the chair, to bed, assisted her to go to the bathroom and up in the wheelchair after a fall despite resident's complaint of hip and leg pain. These procedures were done without waiting to see whether R14 had a fracture and while R14 was in pain from 4:15 AM to 4:40 PM on 4/12/13.

2. R11 had multiple diagnoses which include Parkinson's Disease, Dementia, COPD (Chronic Obstructive Pulmonary Disease) and Mental Retardation. R11 was an 82 year old with original admission to the facility on 7/5/2006. R11 had been hospitalized on 4/8/2013 and readmitted back to facility on 4/18/2013.

Review of latest MDS (Minimum Data Set) dated 4/25/2013 showed that R11 scored 7= severely impaired for BIMS (Brief Interview for mental Status). R11 also required total assistance for hygiene and bed mobility with 1 person physical assist.

On 5/6/13 at 11:15 A.M., R11 was observed in bed, alert, responsive and confused.

Review of current fall risk assessment showed R11 scored as high risk for fall.

Review of the facility incident reports indicated that R11 had fallen 5 times from 6/24/2012 to 3/20/2013. The reports were as follow:
- 6/24/2012 (5:30 A.M.) - R11 was up and tried sitting on the bed. The bed wheels were not locked and the bed moved. R11 missed the bed and fell on the floor.

- 8/13/2012 (7:45 A.M.) - R11 was ambulating to

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dining room from TV room and had slipped on a 12 inches x 12 inches area of wet floor. The written intervention for this fall incident indicated " (R11) has cognitive limitations, language barrier and functional limitations. Remind (R11) to walk with caution in slow pace on the wet floor."

- 12/13/2012 (6:00 P.M.)- R11 was sitting on the bathroom floor. R11 attempted to self transfer to the wheelchair after toiletting , but the wheelchair rolled away and R11 ended on the floor. Incident investigation showed that intervention was to educate R11 to lock wheelchair brakes.

- 2/12/2013 (3:00 P.M.) -" (R11) found on the floor in sitting position in the TV room. (R11) fell over while asleep on his wheelchair."

- 3/20/13 (11:30 P.M.) - R11 found lying on the floor with bleeding forehead. R11 sustained laceration that measures 2.4 cm x 0.4 cm . R11 was monitored, however, continued to have small to moderate bleeding for period of 8 hours. R11 was sent to the hospital at 7 A.M. to suture the lacerated forehead. Review of the conclusion of facility's fall investigation dated 3/20/2013 showed that "(R11) has periods of agitation with impulsive behaviors, tried to get up from bed without asking for assistance."

As indicated above, R11 had cognitive impairment, confusion, language barrier, functional limitations, with periods of agitation and impulsive behavior. The current care plan showed no specific intervention how to monitor and supervise R11 to prevent further fall. As a result of this failure, R11 sustained laceration from the fall of 3/20/2013. The facility failed to provide a

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hazard free environment by ensuring that bed and wheelchair wheels were locked and that the floor was maintained dry.

3. R8 is a 75 year-old with diagnoses of Parkinson's Disease, Dementia with Behavioral Disturbances, General Weakness and Rheumatoid Arthritis. Hospital records printed 3/22/13 indicate R8 has a history of fall.

Review of the facility incident reports indicate R8 had fallen 12 times from 6/9/12 - 3/21/13 as follows:
- 6/9/12 (10:00 AM) - slipped off wheelchair (w/c) while attempting to reach in closet. No injury.
- 6/11/12 (7:00 PM) - fell off w/c while attempting to reach for TV on the floor. Family brought in a TV and put the facility TV on the floor. No injury.
- 6/12/12 (5:30 PM) - fell off the bed while trying to reach for her socks. No injury.
- 6/13/12 (1:00 PM) - tried to transfer from w/c to bed without assistance. No injury
- 9/26/12 (5:20 AM) - fell off the bed while trying to pick up shoes from the floor. No injury.
- 10/18/12 (4:10 AM) - staff eased resident to floor as resident was found sliding off her bed. No injury.
-1/2/13 (6:35 AM) - leaned forward from the w/c with lap cushion. Resident fell along with w/c and lap cushion attached. No injury.
- 2/3/13 (2:15 AM) - found on the floor mattress. Left buttock and hip area reddened.
- 2/7/13 (lunchtime) - CNA (Certified Nursing Assistant) took off lap cushion for lunch in the dining room. R8 fell on her knees and hit forehead on the wall after CNA left resident to attend to other residents. Slight redness to

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forehead.
- 2/13/13 (10:45 PM) - found on the floor on her knees. No injury.
- 3/5/13 (3:45 AM) - found on the floor mattress. No injury.
- 3/21/13 (7:30 PM) - found in the dining room hallway in w/c lying on her side with the w/c and lap cushion still attached. Left eyebrow has bruise and was swollen. Resident was sent to the hospital for evaluation. CT scan and x-ray results were negative.

Incident of 3/21/13 investigation interview with nurse E20 (Nurse) state that E20 was at 2 Main (outside of Alzheimer Unit) passing medications when the incident occurred. R8 was sent to the hospital due to bruise and swelling of left eyebrow. No evidence found to indicate report was sent to the state survey agency. Summary and conclusion report on the fall incident of 3/21/13 indicate that it did not warrant to send report to the survey agency since there was no negative outcome.

Staff interviewed in the Alzheimer Unit on 5/5/13, 5/6/13, 5/7/13 all stated additional help was needed. On several occasions, the nurses could not be found in the unit. When asked where they were, the nurses said they also had to cover Rooms 215 - 221 (11 beds) outside of the Alzheimer Unit.

On 5/8/13 at 10:10 AM on a telephone interview, Z2 (Family Member) of a resident in the Alzheimer Unit stated approximately 2-3 months ago, the evening staff would not show up. Other staff would be assigned to the unit and these staff had "no idea" about the residents. Z2 state that

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the nurse "goes between units" and there would be no nurse available. Z2 state that the Alzheimer unit is not properly staffed.

4. R4 was a 92 year old with multiple diagnoses which include CAD (Coronary Artery Disease) , Glaucoma, and Anemia.

Review of latest MDS (Minimum Data Set) dated 4/5/2013 and 1/3/2013 showed that R4 was assessed as 2/2 for ambulation and transfers(limited assistance with 1 person physical assistance) .

Review of incident report dated 3/28/2013 indicated that R4 fell due to improper transfer. The incident report indicated that E42 (CNA-Certified Nurse Assistant) did not use gait belt during the transfer. The report also indicated that E42 attempted to transfer R4 twice and lifted R4's belt and pants instead of using the gait belt.

Review of facility policy indicated that "Gait Belt usage is mandatory for all resident handling."

5. R3 was admitted to the facility on 02/08/13 with diagnoses including Metabolic Encephalopathy, Acute Respiratory Failure, Depressive Disorder and Cerebro Vascular Accident.

Review of incident/accident report indicated that R3 had several falls on the following dates:

On 02/20/13 at 6:00 PM, R3 was seated on the

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wheelchair in the dining room and a crashing sound was heard by a CNA and R3 was found on the floor.

On 05/07/13 at 3:10 PM, E26 (CNA) stated, "I was putting another resident back in bed and heard a sound. I went out of the room and went to the dining room and saw R3 lying on the floor. Dinner is about to start. There were 2 CNA (E26 and E27) in the unit. E27 was coming out from the farther section of the 2 Main unit. We are in the process of bringing residents to the dining room and there was no staff in the dining room."

According to E7's documented statement report dated 2/20/13, E7 was passing medications and was informed by a CNA that R3 was on the floor.

On 03/07/13 at 10:30 AM, R3 was sitting in reclining chair and was found again on the floor in the dining room.

On 05/07/13 at 11:30 AM, E29 (CNA) stated, "I was pushing a resident towards the dining room and the other CNA was in the hallway. I heard the alarm, went to the dining room and saw R3 on the floor. There was no staff in the dining room then I called the nurse."

On 03/14/13 at 2:30 AM, R3 was found on the floor next to bed.

On 03/26/13 at 1:40 AM, R3 was found again on the floor next to bed.

On 03/28/13 at 12:30 AM, 04/28/13 at 3 PM and 05/03/13 at 3:20 PM was noted again on the floor mat in the room.

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On 05/08/13 at 1:35 PM, E30 (CNA) stated, "I was doing my rounds, and R3's alarm was going on and off and making noise. R3 was in bed getting restless. R3 was halfway trying to get out of bed and then I went out of the room, went to get another and the mechanical to get up R3. When I came back to the room R3 was already on the floor."

6. Review of the Accident/Incident Reports from 4/14/12 to the present, R6 had 7 fall episodes on 6/11/12, 9/1/12, 10/17/12, 1/25/13, 2/16/13, 2/20/13 and 4/20/13.

On 6/11/12 at 5:15 AM, R6 was walking to the bathroom and slipped due to the wet floor. R6 complained of right shoulder pain. Cold compress was applied to the site. R6 was sent to the hospital. MRI (Magnetic Radioactive Imaging) showed right shoulder dislocation.

7. Review of the Accident/Incident Reports indicated that R16 had multiple falls on 5/23/12, 6/5/12, 8/28/12 & 1/4/13.

On 6/5/12 at 12:30 PM, R16 was assisted to the toilet by E41 (CNA -Certified Nursing Assistant) and left the room. Another CNA (former employee) saw R16 trying to stand up from the toilet and almost fell. The CNA grabbed the resident's arm and called for help. The staff nurse came and both staff assisted CNA back to bed. No incident report was written for the near fall until 6/6/13 when R16's right ankle showed large bruise and R16's complained of right ankle pain. The X Ray of the left lower extremity showed fracture of distal fibula right side.

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F9999	Continued From page 81 On 8/28/12, R16 got out of bed unassisted and fell on the floor, bed alarm, mattress and bed bolster came off. On 1/413 at 11:40 PM, R16 was found on the mattress floor by the bedside, sitting down. 8. On 5/5/13 at 8:00 PM by 1 North Unit hallway, the second drawer of the respiratory cart was observed fully opened. There were 4 full boxes of Ipratropium inhalation medications in the drawer. There was no visual control of the cart for at least 15 minutes. No staff was present. E23 (Respiratory Therapist) came out from an identified isolation room at 8:15 PM. E23 stated that she opened the cart to get some respiratory supplies. 9. On 05/06/13 at 12:15 PM, the treatment cart in 1 North Unit was observed parked in the hallway near the nursing station unlocked and unattended. E37 (Nurse) was informed of the above mentioned finding. (B)	F9999		