

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

PRINTED: 03/11/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14G061</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/01/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>IONA GLOS SLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>50 SOUTH FAIRBANK STREET</b> <b>ADDISON, IL 60101</b>		
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W 331	Continued From page 57 (pulse) 46, T 98.0, R (respirations) 12, blood sugar 100. Home 5 nurse notified, 911 called."  "10/9/13 11:30pm: Hospital called per nurse, spoke with charge nurse in ER (Emergency Room) for status, states R26 is now admitted with diagnosis of Septic Shock..."  Further review of R26's record showed that she was in the hospital from 10/8/13 until her discharge back to the facility on 10/22/13.  E2, Director of Nursing, was interviewed on 10/30/13 at 3:02pm. Surveyor asked what was R26's medical status in between 7:45am until 6:30pm. E2 stated, "I can't even begin to tell you." E2 then verified that there is no documentation on nursing monitoring on R26's medical status from 7:45am through 6:30pm on 10/8/13. E2 also verified that R26 was kept home by nursing for medical monitoring.	W 331			
W9999	FINAL OBSERVATIONS  Statement of Licensure Violations  350.1210) 350.1230d)1) 350.1230d)2) 350.1230d)3) 350.3240a) 350.3240b) 350.3240d)  Section 350.1210 Health Services  The facility shall provide all services necessary to maintain each resident in good physical health.	W9999			

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W9999	<p>Continued From page 58</p> <p>Section 350.1230 Nursing Services</p> <p>d) Direct care personnel shall be trained in, but are not limited to, the following:</p> <ol style="list-style-type: none"> <li>1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.</li> <li>2) Basic skills required to meet the health needs and problems of the residents.</li> <li>3) First aid in the presence of accident or illness.</li> </ol> <p>Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator.</p> <p>d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to thoroughly investigate 8 of 8 allegations of abuse and neglect, affecting 5 of 16 individuals who reside in Home</p>	W9999			

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W9999	<p>Continued From page 59</p> <p>6(R1,R2,R4,R6,R15), and 1 of 1 death, involving R5.</p> <p>The facility also failed to thoroughly investigate 1 of 1 injuries of unknown origin (fractured humerus) affecting 1 of 1 clients in the sample (R23) that sustained a fracture.</p> <p>Based on observation, record review and interview, the facility failed to meet the nursing needs for 1 of 1 individual (R5), who expired at the facility when the facility failed to:</p> <ol style="list-style-type: none"> <li>Ensure emergency equipment is working and available,( including oxygen, CPR mask, and ambu bag), and accessible during an emergency situation.</li> <li>Ensure nursing and direct care staff are able to determine when a client is in need of cardiopulmonary resuscitation, and once determined, can initiate immediately.</li> <li>Ensure nursing and direct care staff are knowledgeable on how to respond during an emergent diabetic crisis.</li> <li>Ensure nursing staff ratios for the night shift, are sufficient to provide safe and timely care for all individuals who reside in the facility.</li> <li>Ensure nursing documentation reflects accurate information during a diabetic/cardiac crisis, including time line of progression of event, vital signs, patient assessment, and arrival of emergency medical personal.</li> </ol> <p>Findings include:</p> <p>The Allegation of Physical Abuse Investigation dated 8/28/13, involving R2 was reviewed. This investigation is authored by E8(Quality Manager). The document reads that an allegation of physical abuse was made by R2 to E16(Lead Direct</p>	W9999			

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W9999	<p>Continued From page 60</p> <p>Support Professional) on 8/23/13 at 7:20am. E7(DSP) was the staff member that was alleged to have physically abused R2, and she was placed on Administrative leave pending an investigation of physical abuse. During the interviews conducted during this investigation, new allegations were alleged, that were never formally investigated by the facility. The new allegations raised are as follows:</p> <ol style="list-style-type: none"> <li>1. E4(DSP) - interviewed on 8/23/13 at 2:35pm - E4 stated that she had never seen E7 hit anyone, but that she would just watch E7 because of some of the things that she says, like, "I can't stand him. I wish I could smack his a--," but I've never seen her do it. E4 stated that she has heard E7 tell people to sit down, and if they don't she'll force them to, not shoving to the ground, but definitely pushy. Then the author of the interview(E8, Quality Manager) stated that E4 demonstrated on her by placing her hand on her back, and forcefully guiding her to a chair. E4 also stated that she heard E7 say to R15 to take his a-- back to bed. E8 did not formally investigate who E7 tells to sit down, and physically forces to sit down if they do not sit on their own. E8 did not investigate this new allegation of verbal abuse against R15.</li> <li>2. E5(DSP) - interviewed on 8/23/13 at 3:10pm - E5 stated that she thinks E7 is a little aggressive with R1. E5 was asked to explain what she meant by aggressive, and E5 stated that last weekend, R1 told E7 that he wanted to relax in bed. R1 didn't tell E7 he had a bowel movement. E7 started putting R1's clothes on, and when she flipped him over, she saw BM(bowel movement). E5 stated E7 was rude, and said(to R1), "Why didn't you tell me you had a BM. I shouldn't even</li> </ol>	W9999			

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W9999	<p>Continued From page 61</p> <p>change you because you didn't tell me." E5 was standing in the door, when she over heard E7 say this to R1. E8 did not investigate the new allegation raised by E5 against R1, threatening to leave R1 in his BM.</p> <p>During interviews conducted with this surveyor, new allegations of abuse and neglect were alleged, that were never reported to Administration or Public Health, therefore, never investigated. The new allegations raised are as follows:</p> <p>3. During an interview with R1 on 10/3/13 at 12:15pm., R1 was asked if he has any issues regarding any of the staff members in his home at this current time. R1 stated,"E6(Lead DSP) swears a lot. Every word out of his mouth is offensive. He will say Mother F*****. If an individual has an accident(bowel movement), E6 will be very upset. Every word is a curse word. I go outside, so I don't have to hear him swear. I have requested for E6 to stop swearing. E18(Qualified Intellectual Developmental Professional) and E8(Quality Manager), they both know about it. They had a meeting with him. R4, if he is incontinent, E6 will say, 'This MF messed all over himself.' I am defending the person who can't defend himself. I think this happened in September. I mentioned about R4 and anyone else who might have an accident(incontinence). Instead of calling the individual by their name, E6 calls them a MF. I was afraid to say something to E6. I was just sick of hearing him swear all of the time. E6 was not working for a while after I spoke with E8. He came back yesterday, I think(10/2/13). He was having a conversation with another staff, (E19, DSP), and was referring to another individual outside of work as a MF. He</p>	W9999			

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W9999	<p>Continued From page 62</p> <p>was up front in the living room area. I was the only one who heard it. I was afraid to say something again, because he is the authority in the house. I am afraid he will mentally retaliate against me. He only spoke to me one time, when he came back to work after his leave. In the past, he would talk to me all the time. I told E8, I met with her again because now E6 wasn't talking to me. I told her that I was afraid, and not wanting to go back into the house right away." Though verification of record review, this allegation of mental/verbal abuse was not thoroughly investigated by the facility.</p> <p>4. During an interview with E4 on 10/3/13 at 3:00pm, E4 was asked if she has any issues involving E7 with any of the individuals who reside in Home 6. E4 stated that she has seen E7 physically get R6 to leave the kitchen table, when he doesn't want to get up, by forcing him up. E4 also reported that R15 is always up, and likes to run into the kitchen every night. E4 stated that is when E7 will tell R15 to take his a** back to bed. E4 stated that she did not report the allegations because she is busy around the home. This allegation was never reported to the Administrator, or to Public Health., so therefore was never formally investigated.</p> <p>5. During an interview with E5 on 10/3/13 at 3:15pm, E5 stated that last weekend, she asked E7 to assist with a transfer with R4. E5 explained that R4 was still wet from having had his shower, and was unclothed at the time. E5 stated that E7 said to R4,"Oh, look at your bootie", and then E7 hit him on his bottom while it was still wet. E5 stated she did not report this to anyone, because she didn't want to get anyone in trouble. E5 also raised two other allegations of neglect involving</p>	W9999			

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W9999	<p>Continued From page 63</p> <p>R2 that involved R2 being left in soiled linen on two separate occasions, once in stool and once in urine. E5 stated that the first allegation she reported back in September, but when it happened a second time, she just cleaned R2 up. E5 explained that nothing happened when she reported it the first time, so she didn't bother to report the second incident. This allegation was not reported to Administration or to Public Health, and therefore not formally investigated.</p> <p>During the Daily status meeting on 10/3/13, E1(Administrator), E2(Director of Nursing), and E3(Lead Qualified Intellectual Disability Professional) all were updated on the new allegations raised by E4 and E5 during their interviews with this surveyor. This surveyor explained to E1 that the new allegations occurred in the past, and were not reported to them, or Public Health. E1 stated that all of the staff in Home 6 went through Abuse and Neglect training after the two allegations of abuse in August, and are well aware that they need to report allegations of abuse and neglect as soon as they are witnessed. E1 confirmed that their staff are not following their policy and procedure to report abuse and neglect immediately. E1 stated that they will start their formal investigation on the above allegations immediately.</p> <p>6. The Incident Report Form dated 8/28/13 at 12:40am, involving R5 was reviewed. The document indicates that R5 was found on the floor during rounds for his scheduled blood sugar check. At this time R5's blood sugar level was 41. Glucagon was given as well as applesauce, and his blood sugar rose to 67 at 1:00am. R5 became lethargic, and 911 was called for assistance.</p>	W9999			

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W9999	Continued From page 64  The IDPH Reportable Event Mortality Review involving R5 was reviewed. The date of this event is noted as 8/20/13, however, all other documentation indicates this incident occurred on 8/28/13. This form is undated, and is authored by E1(Administrator). The Summary of Event reads, but is not limited to, "R5 was found on his bedroom floor at 12:40am, by the nurse(E13) who was coming to take his accucheck(blood sugar reading), and Coordinator on Duty(E11), who was in the home. The Coordinator had been in the home and reported that he has(had) observed R5 using the bathroom around 12:30am. R5 was in seizure like activity, and staff supported him with safety measures. Accucheck taken, results were 41. Glucagon 1mg(milligram) given. R5 was assisted to a seated position and applesauce by mouth was given. At 1am, accucheck re-checked, results were 67 and the seizure like activity had stopped. R5 appeared lethargic, but was alert and responsive to tactile stimulation, in a sitting position per staff assist, coughed but remained lethargic. R5 continued to be monitored by the nurse and staff. At 1:10am, R5's pulse was noted to be weak and thready. 911 was called and arrived at 1:16am. The Coordinator reported that as the 911 personal were walking in, R5's color changed, and he went limp. Emergency measures started by EMT(Emergency Medical Team). At 1:31am, R5 was pronounced dead by Z1(Physician), via telemetry strip.  R5's Nursing Notes for the date of 8/28/13 were reviewed. The entry timed 12:40am, reads, but is not limited to, "Nurse in Home #5 during rounds in assigned room of R5 found on floor, accucheck taken results 41, glucagon 1mg IM given to L(left)	W9999			



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W9999	<p>Continued From page 65</p> <p>thigh. Pt(patient) helped to sitting position, applesauce P.O.(by mouth). R5 in seizure like activity. Staff assist with safety measures, Coordinator, 2 DSP(direct care staff)." This entry, as well as the next four entries are authored by R13(Licensed Practical Nurse).</p> <p>1:00am. It reads, but is not limited to, "Accucheck results 67. Seizure like activity stops. Pt seems lethargic, cold towels placed. Remains alert and responsive to tactile stimuli. (non-verbal), now in sitting position per staff assist, a cough but remains lethargic."</p> <p>1:10am. "R5 now unresponsive. Pulse is weak and thready. 911 called for assist."</p> <p>1:16am. "Fire Department on scene per 6 man assist. CPR started. AED machine in use. Patient intubated and bagged with mask for breaths while chest compressions administered....Epinephrine x2 doses given...CPR continues."</p> <p>1:30am. "Fire chief gives orders for assist to call hospital for permission to cease CPR. Z1(physician) at ER gives permission to stop CPR and time of death at 1:31am...all efforts to maintain airway breathing and circulation stopped."</p> <p>The Paramedic Final report involving R5 for the date of 8/28/13 was reviewed. The incident times recorded are as follows: 1:02 am - Dispatched. 1:03 am - Enroute. 1:08 am - At Scene. 1:10 am - At Patient. 1:47 am - Depart Scene.</p>	W9999			

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W9999	Continued From page 66  During review of nursing notes, documentation reflects omission of any recorded vital signs during R5's diabetic and cardiopulmonary crisis on 8/28/13. R5's blood sugar log was also reviewed. For the date preceding R5's diabetic crisis(8/27/13), R5 did not have an entry for his lunch blood sugar level, nor any indication insulin was administered. R5's Physician Order Sheet dated 8/15/13 was reviewed. R5 has an order to receive blood glucose monitoring before meals and at bedtime, and receives Humalog Insulin sliding scale coverage at these same times, as well as should have received 7 units of Humalog Insulin with his lunch meal. R5 also has PRN(as needed) medications, for any potential diabetic crisis, including Glucagon 1mg Sub Q or IM as needed for blood glucose values less than 50, when patient is unable to take oral glucose replacement, and Glucose chew tablet(4mg), chew 3 tablets by mouth as directed as needed for blood sugar less than 80(may have juice). There is no mention for applesauce to be administered in R5's orders. Review of the Paramedics report in relationship to times in the nursing notes does not correlate with each other; nursing notes indicate 911 was called at 1:10am, but the paramedic report indicates the call was dispatched at 1:02am. Nursing notes indicate paramedics arrived on scene at 1:16am, but the paramedic report indicates they were at the patient by 1:10am.  E10(Direct Care Staff) was interviewed on 10/8/13 at 3:00pm., via the telephone. E10 was asked to give her explanation on what occurred during R5's diabetic episode on 8/28/13. E10 explained, "E15 and I were working with R5. He was in the bathroom by himself. We didn't feel	W9999			

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W9999	Continued From page 67 like anything was going on with him. At 12:40am, we found him on the floor in his bedroom. The nurse, E13 was with him, as well as the Coordinator, E11. I told the nurse that R5 needs something right away. She gave him applesauce first, and then I think something to drink, maybe milk. R5 is supposed to get a shot(glucagon), but staff had to tell E13 what to do. The nurses are usually very quick, but E13 was just not on it. When a person's blood sugar is low, she should get the shot right away. Staff shouldn't have to tell the nurse what to do. It wasn't until we said something before she gave him the shot. R5 was on the floor shaking a lot. I thought the shot would bring R5's sugar back up, but he paled and dropped back down on the floor. E13 stepped out(of the house). I think she was looking for an oxygen mask, but when she came back she said she couldn't find it. She left the building for a good five minutes. She said she was looking in other places and in our home, and calling other homes for oxygen. R5 had a faint pulse. I felt like he wasn't breathing. He just stopped moving. He turned blue, and the staff checked his pulse. The nurse was trying to take his blood pressure, but it was reporting error or "0". There was nothing showing. She tried it again. She looked for the oxygen after trying to take his blood pressure. I felt like he wasn't breathing, and not responding. The staff, E15 took his pulse, not the nurse. Nothing was working. I think the nurse called 911, she was out in the living room then. Then she was asking me to look in the medicine cart for the oxygen mask." The surveyor asked E10 if she told anyone about her concerns related to this incident. E10 stated, "I told the Home Manager, E12, about it the day after. I was very traumatized about this incident. I told E12 every detail. She told me that I needed to speak with	W9999			

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W9999	<p>Continued From page 68</p> <p>E1(Administrator). I told her that E1 would not hear me out. I went to speak with E1, but she kept cutting me off. E1 told me that nursing did their job. I told E1 that R5 was not breathing, and that he should have had CPR. I told E1 the nurse was right there, and she was looking for an oxygen mask, so I am pretty sure she thought R5 needed CPR too. But R5 didn't get CPR until the paramedics arrived. I think if the nurse had responded faster, the outcome would not have been this bad. When I tried to tell E1 about it, she said we did all the right things. I told her that personally I felt E13 did not do all the right things, but E1 said that I am not aware of all the things E13 did. E1 told me to talk with E2(Director of Nursing) if I had any concerns; that E2 said that R5's kidneys just collapsed. I was even thinking I should call Public Health because E1 cut me off, because she said that the DON said it was all ok. I told E1 that I should leave because she did not want to hear me. I feel like the nurse took her sweet time, and that E13 should know what to do."</p> <p>E13(Licensed Practical Nurse) was interviewed on 10/9/13 at 9:15am. E13 was asked to provide an explanation of the incident that occurred on 8/28/13 with R5, during his diabetic crisis. E13 stated, but is not limited to, "I was the only nurse on third shift that day. I was in the house, doing rounds, because I was coming to take R5's blood sugar. R5 is very brittle, and we do an extra blood sugar reading around 12:30am. I have been here 6 months, and do not know R5 very well. He is usually just sleeping when I see him. I took his blood sugar, it was 41. He was wiggling all around. E11 was trying to hold him, but he was so strong. I got glucagon, and gave it on his thigh. I gave him applesauce with sugar in it. He</p>	W9999			

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W9999	Continued From page 69 was in seizure like activity. The staff knew him better, I think he was just tired. I put a cold towel on him, and then he went unresponsive. I took his pulse, he was hot from all that thrashing around. I didn't get his respirations. I don't remember what his blood pressure was. I left the home and went to the Administration building. I don't remember when I did that. I had notes with times and vital sign information, but I lost my note paper. I called paramedics because I needed help. R5 didn't have a diagnosis of seizures, so I kept thinking why is he acting like this, so I called 911. He was turning purple, red, then purple. I tried getting a blood pressure, but I couldn't get it. No one ever told me that R5 acts like this when his blood sugar gets so low. It was all happening so fast. When I went to get the oxygen tank in the Administration building, it didn't have a reservoir or a key, so it wouldn't turn on. There was no CPR mask available either. I was thinking that I was going to have to start CPR without a mask, but his face had secretions on it. Then the paramedics came in, and they started CPR. I was thinking everything was on me. There should be one more nurse. We didn't have an oxygen tank that worked, and we didn't have an ambu bag. I told E2(Director of Nursing) about it. She came in that day. I told her I ran for the oxygen, but there was no adapter. I ran back to the home, and R5 was turning colors. The only thing that saved me was the paramedics coming in the door. I couldn't find a CPR mask. I assumed it would be in the medicine cart. I told E10 to look for a mask. There was none. If the same situation were to happen again, I would just call 911 right away. I don't have what I need. I don't have anything to work with; no regulators on the oxygen tanks, no key for the tanks, no masks. There are no tanks in the homes, you have to run	W9999			

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W9999	<p>Continued From page 70</p> <p>up to the Administration building for oxygen. There is only one nurse on night shift, except for Thursdays, when there are two nurses. It was a lot for one nurse to handle. E2 stayed with me the rest of the night. I talked with E1 the next morning. She(E1) was saying that she knew we did all we can. I told her that this never happened to me before. I told E2 the oxygen tank is not working, but she never got up to check it. I didn't have a key, I keep forgetting to bring in mine from home. E2 asked me if I remembered my times for my charting, but I told her I lost all of my time sheets. I tried to chart to the best of my knowledge, like when I called 911 and stuff like that, but it was hard to keep straight."</p> <p>This surveyor spoke with the rescue fire station that responded to the 911 call on 8/28/13, and was able to obtain a copy of the Paramedics final report. Under Narrative Summary of Events, it reads, but is not limited to, "...Upon our arrival found a 52 year old male patient lying supine on the floor pulseless and apneic. Staff states they found him on the floor, and thought he was having a diabetic issue. They checked his blood sugar, and found it to be 41. They then administered 1 mg Glucagon to the patient. Crew immediately verified with cardiac monitor that patient was in asystole and began CPR. Airway had some secretions in it and the airway was suctioned...CPR continued...no change in patient status, patient is with persistent asystole....hospital contacted with patient status and request to withdraw resuscitative efforts....Hospital grants request to hold resuscitative efforts and pronounces patient in the field. Time of death 0131 hours."</p> <p>E1 and E2 were both interviewed together on</p>	W9999			

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W9999	<p>Continued From page 71</p> <p>10/9/13 at 11:40am. E1 was asked if she had any other formal investigation other than the final report that was sent to Public Health. E1 stated that she had some notes, but no other formal report. E1 brought her hand written notes with her to this interview for reference. E1 was asked if E10 came to her with any concerns about the diabetic crisis incident involving R5 on 8/28/13. E1 stated that E12 had told her that E10 came to her with concerns, and that she referred E10 to her(E1). E1 confirmed that E12 did not write any of the issues down formally, but just brought E10 over to speak with her. During the discussion with E10, E1 stated that she told E10 that they did everything that could have been done for R5. E1 was asked if she was aware that E13 had to leave to look for oxygen. E1 stated she was not aware. E1 stated that she referred her to speak with E2 because E2 would be able to address E10's concerns better, since she was a nurse, and could answer all of E10's medical issues better than she could. E2 stated that E13 did call her that night, and told her that she was not ok. E2 stated she came in, and tried to fix everything. E2 stated that she felt that the staff had seen R5 crash so many times before, that he would just snap out of it. E1 added that she did not see the paramedics report, and thought that he just went unresponsive just as 911 entered the door. E1 confirmed that their facility failed to thoroughly investigate this death investigation.</p> <p>7. The Incident Report dated 2/9/13 involving R23 was reviewed. The Incident Report identifies that on 2/9/13 at 8:16pm R23 was observed to have bruising to his upper left arm with swelling and indication of pain. E21 (nurse) documented, "Large discoloration</p>	W9999			

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W9999	<p>Continued From page 72</p> <p>area to (left) upper arm with swelling and indication of pain when touched and moved." "Staff reported discoloration to (left) upper arm. Upon assessment large discolored area to bicep, outer arm and armpit area with moderate swelling. Pain indicated on touching and movement." E21 documented that R23 was to be sent to the Emergency Room for evaluation. E22 (nurse) documented on 2/10/13 at 1:00am R23 returned to the facility with a diagnosis of a left shoulder fracture.</p> <p>R23's hospital Radiology Report, dated 2/9/13, was reviewed. Impression notes, "Transverse fracture involving the anatomic neck of the left humerus with severe displacement of the entirety of the humeral head both inferiorly and laterally."</p> <p>E12 (Home Manager) was interviewed on 10/30/13 at 2:10pm. E12 verified that she completed the investigation of R23's injury of unknown origin. E12 documented that R23, while ambulating in his home, may have lost his balance and fell into a wall hurting himself. E12 identified R23's supervision level as every 30 minutes. E12 explained that staff are to check and observe R23 every 30 minutes. E12 stated that on Saturday 2/9/13 at approximately 8:15pm, E35 (direct support person) was assisting R23 to take a shower when E35 noted that R23 was having difficulty removing his shirt. E35 notified the nurse who then assessed R23. R23 was taken to the ER (Emergency Room) where he was diagnosed with a Fractured Humerus. E12 stated that on Saturday, 2/9/13, 2 direct support staff were working in Home 1 where R23 resides. E12 identified E35 and E36 (direct support persons) as the staff working in Home 1</p>	W9999			



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W9999	<p>Continued From page 73</p> <p>during the 2nd shift (2pm - 10:30pm). E12 stated that E35 and E36 were interviewed regarding R23's injury of unknown origin. E35 and E36 did not observe how R23 sustained his injury. E12 was asked if any other staff were interviewed regarding R23's injury of unknown origin. E12 stated that 2 additional direct care staff were interviewed. However, E12 stated she was not sure if these 2 staff had any contact with R23 on 2/9/13 or when they last observed R23. E12 was asked if any 1st shift staff or 3rd shift staff - prior to R23's injury - were interviewed. E12 stated that no additional staff were interviewed. E12 was asked if any staff were interviewed to determine when R23 was last observed without an injury. E12 stated that no additional interviews were obtained. E12 was asked if the nurse or physician were interviewed to estimate when R23's injury may have occurred based on the bruising or how R23 was injured based on the type of fracture. E12 stated that the physician and / or nurse were not interviewed. E12 was asked how it was concluded that R23 may have fallen while ambulating in his home. E12 stated that an environmental check of R23's bedroom was done and it is possible that R23 may have caught (bumped) the corner of the bed and fallen. E12 was asked, if R23 fell while in his bedroom, should staff have heard him fall. E12 stated that staff should have heard R23 if he fell in his bedroom.</p> <p style="text-align: center;">(B)</p>	W9999			

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