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	146146	A. BUILDING _____ B. WING _____	C 09/08/2015

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HAMILTON MEMORIAL REHAB & HCC	**609 SOUTH MARSHALL MCLEANSBORO, IL 62859**

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F 000	INITIAL COMMENTS	F 000		
F 157 SS=D	Complaint Investigation 1554726/ IL79738 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 157	Continued From page 1 by: Based on observation, interview and record review the facility failed to notify the physician and the designated Power of Attorney with changes in condition for two residents (R1, R2) in a total sample of 4 residents reviewed for resident's rights. Findings include: R1 1.On 9/3/15 at 1:30 PM, Z1's POA (Power of Attorney) stated the facility had only said R1 had fallen and had a small knot on her head. Z1 stated he come into visit R1 the previous weekend on 8/29/15 and she had bruising all around both eyes and looked horrible. Z1 stated the reason he had come into the facility was because his (Z1) granddaughter had been in the week after R1 had fallen and taken pictures of R1's injuries. Z1 stated his granddaughter sent him the pictures because R1 looked so bad and she (granddaughter) was concerned. Z1 stated he came to the facility because he intended to find out what was going on with R1 because this was the second time R1 had fallen and hit her head. Z1 stated the nurse he talked to the day R1 fell stated R1 had fallen and R1 only had a bump on her head but everything was fine. Z1 stated had he been told R1 was having that much swelling and such extensive bruising and what look to be such a bad injury to him, then he would have insisted R1 be sent to the hospital to get looked at immediately and get X-rays or scans done or something. On 9/1/15 at 10:10 AM, R1 with dark yellow discoloration and some light brown discoloration around both eyes, across bridge of nose and up into forehead region. R1 with raised area on forehead more to right measuring approximately 3 cm (centimeters) X 3 cm.	F 157		

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F 157	Continued From page 2 R1's Health status note dated 8/8/15 at 11:39 AM shows that at 8:40 AM the resident was in the dining room and leaned forward in chair and fell to floor. Sustained a 7 cm (centimeter) x 6 cm hematoma to left side of forehead. Neurological assessments initiated. Physician and POA notified. R1's Neurological assessment done on done per the facility policy shows on 8/10/15 on the 2-10 shift her pulse was abnormal at 110 and on 8/11/15 on the 2-10 shift her pulse was abnormal at 102. No documentation can be found where the physician or POA (Power of Attorney) was made aware of the abnormal pulses or the resulting abnormal neurological assessment on 8/10/15 or 8/11/15. On 9/8/15 at 10:00 AM, E2 DON(Director of Nursing) stated the physician and POA are to be made aware of any abnormal vital signs or abnormal assessments. R2 2. R2's Illinois Statutory Short Form Power of Attorney for Health Care dated 12/3/14 shows under 5. If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable, I name the following (each to act alone and successively, in order named) as successor to such agent: 1: Z8 (POA #1) 2: Z9 (POA #2) 3: Z10 (POA #3) R2's Social Service Note dated 8/6/15 at 4:30 PM shows that phone call received from Z8 (POA #1). Discussed need for care plan meeting with her to discuss resident behavior. Z8 states that Z10 (POA #3) has accepted the responsibility of primary Health Care Power of Attorney and she is stepping down from that roll. Message left for Z10 to call facility to discuss behaviors. On 9/8/15 at 2:00 PM E7 (Social Service Director)	F 157		

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F 157	Continued From page 3	F 157		

stated she was the one who wrote note regarding R2's POA change on 8/6/15. E7 stated she did not know who Z9 (POA #2) was and that she was just doing was Z8 (POA #1) had requested she do. E7 stated she should have followed R2's Health Care Power of Attorney form. E7 agreed this would be the legal document for R2's wishes.
R2's Health Status note dated 8/7/15 at 10:57 AM stated spoke with Z10 (POA #3) in regards to behaviors and the fall this am. In regards to the fall, I gave him and update that we had sent her to ER (emergency room) for evaluation. (author was E2 DON).
On 9/8/15 at 1:00 PM E2 stated she had no idea Z10 was not the correct person to be notify according to R2's Healthcare Power of Attorney and she was just going by what Z8 had request them to do.
No documentation was found regarding POA notification regarding findings at ER visit or doctor recommendations on 8/7/15 after her return and subsequent visit.
According to E2's document of review of events dated 9/8/15 shows R2's first emergency room visit has no documentation of notification of POA upon arrival back to facility. No documentation of weekend of continued pain.
On 9/3/15 at 11:40 AM, E2 stated as far as she knew no one had notified any of R2's POA's of her results of X-rays, labs or doctors recommendations from Emergency room visit on 8/7/15. E2 stated this should have been done.
R2's general instructions from the emergency department dated 8/7/15 shows doctor aware at 11:04 AM and wants patient sent back to Nursing home in two if not better.
R2's Health Status Note dated 8/10/15 at 10:25 AM shows Reported residents continued complaints to right hip pain. Resident is not

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F 157	Continued From page 4 bearing weight on right hip during transfers. Two assist to transfer. On 9/3/15 at 11:40 am, E2 stated that if R2 or any resident is having any issue then the nursing staff should have made the doctor and the POA. E2 stated the R2 had a change in her condition over the weekend of 8/7-9/15 because she was having a significant increase in her pain level as well as a decline in her mobility and she did not know why her nursing staff had not contacted the doctor. E2 stated that nursing can and should at least make sure the on call doctor was contacted. E2 also stated and the POA was not made aware and should have been. E2 stated she had already discussed the problem with her nursing staff. According to the facility policy titled " Neurological Assessment "dated 2/14 shows that the pulse usually increases with Intracranial pressure and any change in vital signs should be reported to the physician immediately According to the facility policy titled " Notification and Significant Change of Condition Policy " dated 1/07 shows the purpose is to ensure that the resident's family and/or legal representative and physician are notified of resident changes that fall under the following categories: A significant change in the resident's physical, mental or psychosocial status. (See below for examples:) -Significant change in/or unstable vital signs - New wounds, bruises or skin tears -abnormal, unusual or new complaints of pain -other abnormal assessment findings Procedure: When any of the above situations exists, the licensed nurse will contact the resident's family and their physician. The physician will be contacted immediately for any emergencies regardless of the time of day.	F 157		

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F 157	Continued From page 5 Non-emergency notifications may be made the next morning if the situation occurs on the late evening or night shift. If the physician cannot immediately be reached in any emergency the medical director will be called. If that physician cannot be reached, the director of nursing or the charge nurse can make arrangements for transportation to the emergency department. In non-emergency situations, the primary physician will be called unless he/she has left an alternate name to call. If after two attempts, there is no response to the calls, the medical director will be contacted. Each attempt will be charted as to the time the call was made, who was spoken to, and what information the physician was given. According to the facility's document titled " Charting and Documentation "dated 5/08 shows under statement that the policy is all services provided to the resident, or any changes in the resident's medial or mental condition, shall be documented in the resident ' s medical record. -All observations, medications administered, services performed, etc., must be documented in the residents clinical records -All incidents, accidents, or changes in the resident's condition must be recorded.	F 157		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to notify the physician of change and new onset of pain and manage pain for one resident (R2) in a total sample of 4 residents reviewed for pain. This failure resulted in R2 experiencing pain at a voiced level of "excruciating" and "4-8" on a scale of 1-10, over a three day period and not being medicated regularly for pain after a fractured hip with anticipating healing of 6-12 week period. Findings include: R2's Health Status Note dated 8/7/15 at 1:27 AM shows that at 12:50 AM, the nurse was sitting being nurse station and heard a loud noise and went in to check on resident in room and found resident sitting upright in the floor between her bed and her recliner. During assessment found 4 cm x 2 cm skin tear to right elbow. The nurse cleansed sit with skin integrity and applied 7 steri strips. Nurse found another skin tear measuring 2 cm x 1 cm to lower back. The nurse cleansed with skin integrity and applied 4 steri strips. Another skin tear noted to anterior right lower extremity measuring 4 cm x 2 cm. The nurse cleansed site with skin integrity and applied 6 steri-strips. Resident denied having any pain or discomfort. Resident stated " I'm Fine. Faxed and notified doctor. Will continue to monitor. No documentation was found where R2's range of motion was assessed after fall on 8/7/15. No documentation of neurological checks initiated per facility policy and procedure for this residents fall incident could be found. E2's statement of review dated 9/8/5 shows R2's first visit to emergency room has no documentation of notification of POA (Power of Attorney) upon arrival back to facility. No	F 309		

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documentation of notification over weekend of continued pain. No neurological checks on R2's fall initiated.
On 9/3/15 at 11:40 AM E2 DON (Director of Nursing) stated with any fall staff should all assess range of motion and should document what it is and if it was not documented it did not happen. E2 stated the nurse on duty when R2 fell on 8/7/15 should have initiated a neurological check because it was an unwittnessed fall and the facility policy was to initiate with unwittnessed falls. E2 stated this is to help assess a residents pain level also
On 9/8/15 at 10:00 AM E2 DON stated E11 RN(Registered Nurse) that had been on duty the night of R2's fall had since resigned and she had been unable to speak to her regarding what had actually occurred or not occurred the night R2 had fall of how or if R2's pain was actually assessed
On 9/8/15 at 9:30 AM, Z3 (Therapist) stated she was familiar with R2 and had treated her off and on since her admission. Z3 stated at the time of her fall on 8/7/15 she was ambulatory with stand by assist but knew there had been issues with her trying to leave the facility. Z3 stated that as of this time R2 was now in a wheel chair and partial weight bearing due to the fracture of her hip that occurred with her fall on 8/7/15. Z3 stated any time a person has a fracture it will be painful. Z3 stated she had come in the morning or 8/7/15 to do therapy for R2's roommate around 7:00 AM. Z3 stated R2 was in bed and was complaining to her of having " excruciating " pain in her right hip and thigh area. Z3 stated this was very unusual for R2 as she had never complained of pain before this. Z3 stated she got the physical therapy assistant and they both assessed R2. Z3 stated that R2 was complaining of pain in her

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back, right hip and upper leg. Z3 said at that point she went and immediately notified the day shift nursing staff. Z3 stated she did not know how R2 was assessed on nights but as soon as she tried to do anything as far as range of motion R2 complained of " excruciating " pain and had facial grimacing. Z3 stated she was unable to even really turn and reposition R2. Z3 stated any hip fracture is going to be painful.

On 9/3/5 at 9:30 AM, Z4 (Therapist) stated she had been called to R2's room by other therapist(Z3) because she was concerned about her complaints. Z4 stated that R2 was complaining of a lot of pain. Z4 stated at the time she saw Z4 she was in bed and she could not bear weight and any time they tried to move her she was in pain and was having facial grimacing. Z4 stated any time a person had a fracture or a fractured hip then they're going to have a lot of pain for a while. Z4 stated that before R2 fell and fractured her right hip she was up and walking around the facility with a walker. Z4 stated at this time R2 was unable to do any type of therapy and was only partial weight bearing on her right leg due to her fractured hip.

According to Emergency room X-ray report dated 8/7/15 impression shows: lucency right greater trochanter, favored to be artifactual, with nondisplaced fracture not entirely excluded. Recommended correlation with radiography right hip or CT (computed tomography) for further evaluation. Doctor aware and wants R2 sent back to nursing home and monitor and do CT if not better in two days.

R2's MAR (Medication Administration Record) for August 2015 shows resident complaining of pain on a scale of "4 & 8 " on a scale of 1-10 for 8/7/15 (Friday), 8/8/15 (Saturday), 8/9/15 (Sunday). No documentation can be found were

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doctor was made aware of increase in resident's pain level after fall on 8/7/15. Review of R2's MAR for June, July and 8/1-7/15 has her normal pain level of "0".
R2's Health Status Note dated 8/10/15 at 10:25 AM shows reported resident continues to complain of pain to right hip and leg.
R2's document titled CT right hip without contrast dated 8/10/15 stated under impression mildly displaced fracture of the right hip.
According to R2's Health Status Note dated 8/14/15 at 12:19 PM, R2 to orthopedic appointment and does have a right hip fracture, no surgery needed but very painful break, may pivot for transfers, partial weight bearing as tolerated to right foot.
According to document titled " Neuromuscular Orthopedic institute " dated 8/14/15 shows she has she has a fracture of her right hip. Healing will take 6-12 weeks. Will allow her to be partial weight bearing on her right lower extremity as tolerated. She is going to be at reduced activity level for a while because of the pain.
On 9/3/15 at 12:05 AM, E2 DON stated she did not know why the nursing staff over the weekend of 8/7/15 to 8/9/15 did not make the doctor aware of R2's increase and change in pain after her fall on Friday 8/7/15. E2 stated that the nursing staff should not have waited all weekend and allowed R2 to have been experiencing pain at such a high level. E2 stated that she did not feel R2's order for acetaminophen was going to be effective for R2 type of pain considering R2 probably had a fractured hip at that time. E2 stated she had questioned her nursing staff as to why they had not notified the physician and had not been given and answer. E2 stated this was obviously a problem and she was trying to resolve it and pain should always be treated and treated with a

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medication that is most effective and the doctor should be notified immediately of any change as soon as needed. E2 stated a hip fracture can be very painful and stronger pain medication than acetaminophen would be needed to alleviate the pain. E2 stated that is why she had made sure the physician was called on 8/10/15 for an order for the pain medication Norco. E2 stated her expectation was that R2 was being given this medication on a fairly regular basis because of the pain related to this fracture. E2 confirmed that the orthopedist had also stated this was a painful fracture and would cause a change in her activity. E2 stated at this time R2 was mobile with a wheelchair and partial weight bearing to her right leg and not to ambulate and no therapies at this time and to have assist with all transfers.
On 9/3/15 at 10:20 AM, E9 CNA (Certified Nursing Assistant) was in R2's bathroom and had her on the toilet. E9 had no gait belt on R2. E9 stated R2 had gotten herself out of her bed and put herself in her wheelchair. E9 stated that when she entered R2's room her body alarm was going off and R2 had managed to transfer self from bed to wheelchair in that time. E9 then proceeded to transfer R2 from the toilet to the wheelchair with no gait belt. R2 was noted to bear weight on her right leg and had facial grimacing. E9 then transferred R2 from her wheelchair to her bed without the use of a gait belt. R2 again was noted to bear weight on her right leg and had facial grimacing.
On 9/3/15 at 10:35 AM, E9 CNA stated she should not have transferred R2 without a gait belt and there is a great change for injury to the resident. E9 gave no indication she was aware of facial grimacing and indications of pain during transfers and weight bearing.
On 9/3/15 at 11:00 AM , E5 LPN(Licensed

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Practical Nurse) stated that any time a staff transfers a residents a gait belt should be used. E5 stated R2 was partial weight bearing status to right leg due to her recent fractured hip. E5 stated the last time she had a Norco pain pill was 8/16/15. At this time survey made E5 aware R2 had been transferred by E9 without gait belt and was in bed asked if pain assessments need to be done. E5 stated pain assessment is done every shift and she can tell you if she is hurting.
On 9/3/15 at 12:40 PM, E2 DON, stated E9 should not transfer without gait belt for resident safety. E2 stated facial grimacing is an indicator of pain and should be assessed. E2 stated R2 is at increased risk for pain due to recent fracture and should be assessed for pain on on-going basis. E2 stated at this time R2 is only to be partial weight bearing on right leg due to fracture.
According to R2's Health Status Note dated 9/6/15 at 8:20 PM shows at 7:55 PM resident found sitting in floor beside her bed. She had apparently put herself to bed and was attempting to get back up into her wheelchair and the brakes were not locked. She states that she does not hurt anywhere, but she has a 3 cm scratch behind her ear on the left side of her head.
On 9/8/15 at 2:00 PM, E2 DON stated that she had just started her investigation to this fall when she had come in this morning. E2 also stated that when she asked about R2's pain management that the nurse on duty E8 RN (Registered Nurse) stated that R2 was just having her " regular pain ". E2 stated she asked E8 why R2 was having " any pain " let alone "regular pain " when the nursing staff was to be assessing R2 for pain every shift and R2 had pain medication available. E2 stated E8 was unable to answer her question. When questioned E2 was not aware that R2 had not received any pain

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HAMILTON MEMORIAL REHAB & HCC	**609 SOUTH MARSHALL MCLEANSBORO, IL 62859**

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medication since 8/16/15. E2 stated R2 should have been receiving some kind of pain relief per the orthopedic doctors recommendations and that's why she (E2) had gotten the Norco order but apparently after the incident with R2 on 9/3/15 and 9/6/15 the staff do not understand how pain needs to be addressed and obviously education needs to be done with all staff. E2 stated R2's pain is not being managed at this time.
On 9/8/15 at 1:00 PM reviewed R2's MAR (Medication Administration Record) and progress noted regarding her pain management and assessment. No documentation was found where resident was assessed or medication for indicators of pain after facial grimacing with improper transfer on 9/3/15 and staff was made aware. Review shows last Norco was given on 8/16/15.
R2's Health Status Note dated 8/14/5 states R2 went to orthopedic appointment at 9:10 AM, review of R2's MAR shows no pain medication administered prior to this appointment. On 9/8/5 at 2:00 PM, E2 stated nursing staff should have medicated R2 with the pain medication Norco prior to her appointment for pain management. On 9/8/15 at 2:00 PM E2 stated nursing staff should have medicated R2 for pain after her fall on 9/6/15.
R2's Restorative note dated 9/5/15 at 5:44 shows R2 continues with active range of motion, ambulates to dining room in the evening with gait belt and one assist, she is compliant with exercise and walking. On 9/8/5 at 3:00 PM, E2 stated R2 was still partial weight bearing to right leg due to fracture when questioned about being walked on 9/5/15 was unable to answer.
According to the facilities policy titled "
Falls-Clinical Protocol " dated 5/13 under treatment and management it shows that based

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F 309	Continued From page 13 on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. The staff, with the physician ' s guidance will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. Delayed complications such as late fractures and major bruising may occur hours or several days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall According to the facility policy titled " Pain-Clinical Protocol "dated 5/13 shows the nursing staff will assess each individual for pain whenever there is a significant change in condition and when there is onset of new or worsening of existing pain. The staff will identify the nature and characteristic such as location, intensity, frequency, pattern, etc. as well as severity of pain. The staff will observe the resident (during rest and movement) for evidence of pain: for example, grimacing while being repositioned. The staff will identify any situations or interventions where an increase in the resident's pain may be anticipated: for example ambulation or reposition. The staff and physician will also evaluate how pain is affecting mood, activities of daily living, sleep, and the resident's quality of life, including complications such as gait disturbance, social isolation and falls According to the facility policy titled "Charting and Documentation" dated 5/08 shows all services provided to the residents, or any changes in the residents medical or mental condition, shall be documented in the resident's medical record. All observations, medications administered, services	F 309		

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F 309	Continued From page 14 performed, etc., must be documented in the resident clinical records. All incidents, accidents, or changes in the residents condition must be recorded.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow identified safety interventions and protocols, care plan interventions and facility policy and procedures to prevent falls and injuries for 4 residents (R1-4) in a total sample of 4 reviewed for accidents and injuries. This failure resulted in R2 sustaining a right hip fracture that caused the resident to go from a stand-by ambulatory status to a partial weight bearing status and reduced activity because of pain. Findings include: According to R2's Plan of Care with initiation date of 5/5/15 and target goal date of 11/17/15, R2 is a risk for falls related to falls prior to admission. High risk per fall assessment. Fall 6/20/15, Fall 7/9/15, Fall 7/16/15, fall 8/7/15. The goal is the resident will be free of falls thru the review date (11/17/15). The initiation of this goal is 5/5/15. R2 was also identified as an elopement	F 323		

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F 323	Continued From page 15 risk/wanderer as evidence by history of attempts to leave facility unattended and this focus area was initiated on 8/3/15. R2's noted intervention: assess for fall risk, staff to monitor R2's location every 30 minutes and document wandering behavior and attempted divisional interventions in behavior log R2's Health Status Note dated 8/7/15 at 1:27 AM shows that at 12:50 AM, the nurse was sitting being nurse station and heard a loud noise and went in to check on resident in room and found resident sitting upright in the floor between her bed and her recliner. Resident stated, " I thought that it was time to get up to go down to eat for breakfast. I tried to get up on my own and tripped on my recliner. " The nurse noted resident ' s recliner was close to bed with chair in reclining position. The nurse moved chair away from bed and pushed lever down to remove chair from reclining position. During assessment found 4 cm x 2 cm skin tear to right elbow. The nurse cleansed sit with skin integrity and applied 7 steri strips. Nurse found another skin tear measuring 2 cm x 1 cm to lower back. The nurse cleansed with skin integrity and applied 4 steri strips. Another skin tear noted to anterior right lower extremity measuring 4 cm x 2 cm. The nurse cleansed site with skin integrity and applied 6 steri-strips. Resident denied having any pain or discomfort. Resident was laughing and stated " I'm Fine. I didn ' t hurt anything except for my elbow. I didn't hurt my head. I just thought it was time to get up for the day. " Complete skin assessment performed and helped to transfer resident back into bed. Applied body alarm underneath resident while in bed. Applied derma savers to upper extremities to protect site. Called and notified Z8 (POA #1) about incident. Faxed and notified doctor. Will continue to monitor.	F 323		

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F 323	Continued From page 16 No documentation was found where R2's range of motion was assessed after fall on 8/7/15. There were also no documentation of neurological checks initiated per facility policy and procedure for this residents fall incident. On 9/3/15 at 11:40 AM E2 DON (Director of Nursing) stated with any fall staff should all assess range of motion and should document what it is and if it was not documented it did not happen. E2 stated the nurse on duty when R2 fell on 8/7/15 should have initiated a neurological check because it was an unwittnessed fall and the facility policy was to initiate with unwittnessed falls. E2 also stated with the neurological checks the resident is checked on more often by the nurse of should be. On 9/8/15 at 10:00 AM E2 DON stated E11 RN(Registered Nurse) that had been on duty the night of R2's fall had since resigned and she had been unable to speak to her regarding what had actually occurred or not occurred the night R2 had fall. On 9/3/15 at 11:40 AM, E2 DON was unable to answer why the doctor was faxed instead of actually contacted regarding R2's fall when there was actual injuries with treatments provided. On 9/3/15 at 11:40 AM, E2 DON stated R2 had been on 30 minute checks for safety and supervision. E2 confirmed when staff did these checks they should also be checking for any hazards within the vicinity of the resident. E2 stated that she did not know why R2's recliner what up and out and this is something staff should be checking during the safety checks. E2 confirmed that had the recliner foot rest not been out R2 would not have fallen or the risk would have been greatly decreased. E2 stated the footrest could certainly have contributed to the increase in the injury to R2.	F 323		

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F 323	Continued From page 17 On 9/3/15 at 12:10 PM, E2 DON stated that R2's 30 minute checks are to be done as marked at those intervals. E2 could not explain why on the night R2 fell (8/7/15) that three hours of 30 minute checks where all documented at the same time, then two hours at the same time. E2 stated there was no way to determine if R2 was actually being monitored every 30 minutes or not. E2 stated there was no way to determine or confirm that R2's safety checks were actually done per the facility policy and procedure E2's statement of review dated 9/8/5 shows R2's first visit to emergency room has no documentation of notification of POA(Power of Attorney) upon arrival back to facility. No documentation of notification over weekend of continued pain. No neurological checks on R2's fall initiated. On 9/8/15 at 9:30 AM, Z3(Therapist) stated she was familiar with R2 and had treated her off and on since her admission. Z3 stated at the time of her fall on 8/7/15 she was ambulatory with stand by assist but knew there had been issues with her trying to leave the facility so they had been monitoring her every so often because of this. Z3 stated that as of this time R2 was now in a wheel chair and partial weight bearing due to the fracture of her hip that occurred with her fall on 8/7/15. l. On 9/3/5 at 9:30 AM, Z4 (Therapist) stated the last time she saw R2 she was in bed and she could not bear weight and any time they tried to move her she was in pain and was having facial grimacing. Z4 stated any time a person had a fracture or a fractured hip then they're going to have a lot of pain for a while. Z4 stated that before R2 fell and fractured her right hip she was up and walking around the facility with a walker. Z4 stated at this time R2 was unable to do any	F 323		

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type of therapy and was only partial weight bearing on her right leg due to her fractured hip. Z4 stated anytime she went into a room as a therapist she tried to asses for hazards and a chair with a footrest out with definitely be a cause for a concern for her. Z4 stated if she went into a room and a recliner had a footrest up she would go put it down and move it away from the bed making sure the resident had a safe path to walk to the doorway in.
According to Emergency room X-ray report dated 8/7/15 impression shows: lucency right greater trochanter, favored to be artifactual, with nondisplaced fracture not entirely excluded. Recommended correlation with radiography right hip or CT(computed tomography) for further evaluation. Doctor aware and wants R2 sent back to nursing home and monitor and do CT if not better in two days.

R2's Health Status Note dated 8/10/15 at 10:25 AM shows reported resident continues to complain of pain to right hip and leg. Resident is not bearing weight on right leg during transfers.
R2's document titled CT right hip without contrast dated 8/10/15 stated under impression mildly displaced fracture of the right hip.
According to R2's Health Status Note dated 8/14/15 at 12:19 PM, R2 to orthopedic appointment and does have a right hip fracture, no surgery needed but very painful break, may pivot for transfers, partial weight bearing as tolerated to right foot.
According to document titled " Neuromuscular Orthopedic institute " dated 8/14/15 shows she has she has a fracture of her right hip. Healing will take 6-12 weeks. Will allow her to be partial weight bearing on her right lower extremity as tolerated. She is going to be at reduced activity

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level for a while because of the pain.
On 9/3/15 at 10:20 AM, E9 CNA (Certified Nursing Assistant) was in R2's bathroom and had her on the toilet. E9 had no gait belt on R2. E9 stated R2 had gotten herself out of her bed and put herself in her wheelchair and because she had had a bowel movement on herself. E9 stated that when she entered R2 ' s room her body alarm was going off and had been going off but she had been assisting another resident and did not want to leave them unattended and had responded as soon as possible but, R2 had managed to transfer self from bed to wheelchair in that time. E9 then proceeded to transfer R2 from the toilet to the wheelchair with no gait belt. R2 was noted to bear weight on her right leg and had facial grimacing. E9 then transferred R2 from her wheelchair to her bed without the use of a gain belt. R2 again was noted to bear weight on her right leg and had facial grimacing.
On 9/3/15 at 10:35 AM, E9 CNA stated she should not have transferred R2 without a gait belt and there is a great change for injury to the resident. E9 gave no indication she was aware of facial grimacing and indications of pain during transfers and weight bearing.
On 9/3/15 at 11:00 AM , E5 LPN(Licensed Practical Nurse) stated that any time a staff transfers a residents a gait belt should be used and any staff that hears an alarm whether it ' s a bed, chair or door alarm should respond. E5 stated even if they ' re not nursing they can at least try to make sure the resident is safe. E5 stated that if an alarm is going off long enough for a resident to make it from the bed to a chair or a chair to bed then it probably is going off to long and staff should be responding quicker. E5 stated R2 was partial weight bearing status to right leg due to her recent fractured hip. E5

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stated the last time she had a Norco pain pill was 8/16/15. At this time survey made E5 aware R2 had been transferred by E9 without gait belt and was in bed asked if pain assessments need to be done. E5 stated pain assessment is done every shift and she can tell you if she is hurting.
On 9/3/15 at 12:40 PM, E2 DON, stated if alarm is going off long enough for resident to transfer self from bed to chair or chair to bed then staff is not responding quickly enough and any staff can respond to any alarm and should respond for resident safety. E2 stated E9 should not transfer without gait belt for resident safety. E2 stated facial grimacing is an indicator of pain and should be assessed. E2 stated R2 is at increased risk for pain due to recent fracture and should be assessed for pain on on-going basis. E2 stated at this time R2 is only to be partial weight bearing on right leg due to fracture.
According to R's Health Status Note dated 9/6/15 at 8:20 PM shows at 7:55 PM resident found sitting in floor beside her bed. She had apparently put herself to bed and was attempting to get back up into her wheelchair and the brakes were not locked. She states that she does not hurt anywhere, but she has a 3 cm scratch behind her ear on the left side of her head.
R2's occurrence report dated 9/6/15 at 7:55 PM stated R2 ' s alarm was turned off.

R2's Restorative note dated 9/5/15 at 5:44 shows R2 continues with active range of motion, ambulates to dining room in the evening with gait belt and one assist, she is compliant with exercise and walking. On 9/8/5 at 3:00 PM, E2 stated R2 was still partial weight bearing to right leg due to fracture when questioned about being walked on 9/5/15 was unable to answer.

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F 323	Continued From page 21 2.According to R1's Occurrence report dated 8/8/15 at 8:40 AM, shows R1 was in dining room lying on ground face down and had fallen forward. Under miscellaneous at 1:3 shows R2 's chair alarm was not on. Under conclusion dated 8/9/15 at 7:49 PM shows R1 continues to lean forward in her wheelchair, R1 sustained a bruise to her face and small skin tear to her cheek. Bruise to face has increased in size. On 9/3/15 at 12:10 PM E2 stated she had spoken to the POA the past weekend (9/1/15) and made them aware that after her follow up to R1's fall that she had determined it was the facility staff 's fault that R1 had fallen out of her chair on her fall that occurred on 2/13/15 as well as 8/8/15. E2 stated that according to R1 's care plan she is to have her alarm on while in her wheelchair and it was not on. R2 stated she made the POA aware of this. According to R1's care plan with initiated date of 5/13/15, R1 is risk for falls related to impaired mobility with falls on 2/13/15 and 8/9/15. Under intervention is to have alarms to bed and chair. R3 3.According to R3's Care Plan with date initiated of 4/30/15, R1 is at risk for falls related to unaware of safety needs, gait/balance problems with falls on 5/9/15 and 5/13/15. Interventions stated R3 is to have wedge cushion to wheelchair for positioning. On 9/1/15, 9/3/15 & 9/8/15, R3 was seen in various areas throughout the facility and did not have designated wedge cushion in her wheelchair. On 9/8/15 at 9:30 AM, R3 was in the physical therapy room and Z3 (therapist) was with her and was sitting in same cushion previously noted. Z3 stated that the cushion R3 was on was not a wedge cushion but a standard cushion and that	F 323		

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F 323	Continued From page 22 R3 was not positioned well because she was at the edge of her seat and this would make her more like to slide out of her chair. R4 4. According to R4's Care Plan with initiated of 3/16/15 shows R4 is at risk for falls related to hip fracture with falls on 3/21/15, 5/18/15, 6/1/15, 6/8/16, 6/11/15, 7/1/15, 8/21/15 and 8/30/15. Intervention for R4 to use a bed/chair electronic alarm and ensure the device is in place as needed and working correctly with initiation date of 7/10/15. On 9/3/15 at 10:11 AM R4's chair alarm started sounding. No staff responded to R4's alarm until 10:16 AM. When staff responded R4 had transferred herself from her bed to her wheelchair. According to the facilities policy titled " Falls-Clinical Protocol dated 5/13" under treatment and management it shows that based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. The staff, with the physician's guidance will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. Delayed complications such as late fractures and major bruising may occur hours or several days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall According to the facility policy titled " Pain-Clinical Protocol "dated 5/13 shows the nursing staff will assess each individual for pain whenever there is a significant change in	F 323		

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F 323	Continued From page 23 condition and when there is onset of new or worsening of existing pain. The staff will identify the nature and characteristic such as location, intensity, frequency, pattern, etc. as well as severity of pain. The staff will observe the resident (during rest and movement) for evidence of pain: for example, grimacing while being repositioned. The staff will identify any situations or interventions where an increase in the resident's pain may be anticipated: for example ambulation or reposition. The staff and physician will also evaluate how pain is affecting mood, activities of daily living, sleep, and the resident's quality of life, including complications such as gait disturbance, social isolation and falls According to the facility policy titled "Charting and Documentation"dated 5/08 shows all services provided to the residents, or any changes in the residents medical or mental condition, shall be documented in the resident's medical record. All observations, medications administered, services performed, etc., must be documented in the resident clinical records. All incidents, accidents, or changes in the residents condition must be recorded.	F 323		