STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146099	A. BUILDING _____ B. WING _____	08/01/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	**1209 21ST AVENUE ROCK ISLAND, IL 61201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Certification and Licensure Incident of 07/22/07/IL30003-F280 and F324 An extended survey was done.	F 000		
F 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to make the results of the last State agency survey readily available to the public. Findings include: On 7/24/07 at approximately 9 AM, a copy of the last State agency survey results could not be located in common areas of the building. A posted notice as to the whereabouts of the survey results also could not be found. Interview with E1(Administrator) at that time indicated that the binder containing the survey results is kept on a shelf in the copier room by	F 167		8/1/07

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 167	Continued From page 1 the main nurses' station, where she then found it. E1 stated that a notice as to the whereabouts of the latest survey results is usually posted on a board by the nurses' station, but she was unable to locate it.	F 167		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews, the facility failed to assess and care plan for pain management for R9 and R2, 2 of 2 sampled residents with recent fractures. Findings include:	F 279		8/1/07

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F 279	Continued From page 2 The facility policy "Pain Assessment" states that "1. A comprehensive pain assessment will be completed as part of the initial nursing assessment with development of a pain management programs as indicated. 2. The comprehensive pain assessment will be reviewed quarterly and with significant change in status. 3. Continuing assess of the pain management program will occur daily and will focus on the effectiveness of the program and the comfort level of the resident.....Equipment and Supplies 1. Pain Assessment tool, as indicated per facility protocol." The Pain-Clinical Protocol Policy states that the assessment should include a review of the known diagnosis or conditions that commonly cause or predispose residents to pain....treatments...what the resident is currently receiving for pain....." 1. POS (Physician Order Sheet dated July 2007, states that R2 was admitted to the facility on 5/22/07 with current diagnoses including Sepsis, Urinary Tract Infection, Congestive Heart Failure, Insulin Dependent Diabetes Mellitus, and Atherosclerotic Heart Disease. History and Physical done on 6/20/07 states that R2 had "a fall and sustained a compression fracture of his mid thoracic spine. This has been a continuing source of pain. The patient is on multiple medications for this is pain". E2, Director of Nurses, was asked to provide a Pain Assessment for R2 on 7/23/07 and she related that they do it along with the admission process and then provided the Nursing Admission Assessment Form. The Nursing Admission Assessment dated	F 279		

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F 279	Continued From page 3 6/28/07 has a section on "Pain," which asked for the location, (back) rate (5), on a scale of (1-10). The 5/22/07 Nursing Admission Assessment, also states R2 has pain "Right shoulder/hands, medial back and right leg numb" with a pain rating of 10 out of a scale of 1-10. R2's MDS (Minimum Data Set) dated 5/30/07 states that R2 has moderate pain less than daily in the back, bone and soft tissues. This same MDS states that R2 was admitted with 2 stage 3 pressure areas, 1 stage 4 and 1 stage 2 pressure areas. R2's Medications are Fentanyl Patch 100 mcg./hr. (hour) change every 72 hours; Lortab 5/500 every 4 hours PRN for pain. The "Pain Assessment tool" (form) specified in the facility policy/procedure was not provided. No evidence was seen that this assessment was completed for this resident. Per interview on 7/23/07 at 12:30 p.m., R9 states that he has a lot of pain from the spine fracture and pain in the pressure areas especially with dressing changes. 2. R9's POS (Physician Order Sheet) dated July 2007 states R2 was admitted to the facility on 10/13/05. The POS states that R2 has the diagnosis of diabetes, hypertension, Congestive Heart Failure, weakness, and Status post Right Hip Arthroplasty. Incident Records show that R9 had a compression fracture related to a fall on 6/20/07. 6/24/07 xray confirmed a compression fracture was present. No Pain Assessments were provided indicating a thorough assessment for R9's pain, location, type and rating of the pain. The "Pain Assessment	F 279		

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F 279	Continued From page 4 tool" (form) specified in the facility policy/procedure was not provided. No evidence was seen that this assessment was completed for this resident. R9's Care Guide was not updated to include the pain from the compression fracture. On 7/23/07 at approximately 2:30 p.m., R9 was observed to be lying supine in his bed. R9 complained of a sharp pain in his back. He stated that "just ever so often, I get this pain."	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews, the facility failed to update the fall care guide with interventions after each fall for 5	F 280		8/3/07

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F 280	Continued From page 5 of 6 sampled residents (R1,9,8, 3, and 4) identified at risk for falls, and R17 not on the sample. Findings include: 1. R9's most recent Care Plan dated 5/1/07 states under "Safety Notes: I am at low risk for incidents." There are no interventions listed to prevent falls, nor are the falls listed. R9's Admission diagnosis includes "Status post Hip Repair". R9's Care Plan states under "Social History: Because of weakness I needed to transfer to the health care center for more help." R9 had previously resided in the Shelter Care section of the facility. Facility Incidents list 6 falls for R9 between 9/20/07 and 6/20/07. R9 sustained a fracture of the L4 vertebra with the fall incurred on 5/20/07. On 7/23/07 at the noon meal, R9 was observed to have a body alarm in use which according to the Incident Report dated 6/20/07 was implemented following this fall. 2. R1's Most recent Care Plan dated 4/30/07 states under "Safety Notes: I have a history of frequent falls with the most recent just since this admission to the health care center. I have had a decline in functional mobility with weakness and poor safety awareness. I have a personal alarm for added safety. If you hear it sounding, respond to it immediately (all). My goal is to remain free from injury and incident through the next review." No other interventions were noted in the care plan. Facility Incidents list the 15 falls for R1 between 3/5/07 and 7/16/07. R1 was observed to have a	F 280		

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F 280	Continued From page 6 mat by the side of his bed, a low bed and a wheel chair alarm. 3. R8's most recent care plan dated 7/17/07 states that R8 has "poor safety awareness due to cognitive impairment. I do have a history of falls." No falls are listed. Facility Incident Reports state that R8 has had falls on 2/12/07 and 4/5/07. 4. R4's most recent care plan dated 6/12/07 under "Safety Notes" indicates, "I'm at risk for falls due to poor safety awareness, impaired cognition, behavior problems and a fall in the last 6 months resulting in hip fracture. There is a night light in my room and the staff leaves the bathroom door open for me. My goal is that I will be free from injury related to incidents for the next 3 months. The nurse will report all incidents to my doctor and family. They will record each incident and evaluate for a common cause that may prevent future incidents. Remind me that I am unable to get up per myself and that I need to call for assistance. Ensure the call light is within easy reach at all times that I am in my room. Be sure personal alarm is used at all times for added safety. My last fall was on 5/07." The Incident Reports dated 5/5/07 and 6/12/07 indicate that R4 was found sitting on the floor in front of her wheelchair with no apparent injuries. The care guide does not address these falls and does not provide any new approaches/interventions to prevent future falls. There is no documentation to indicate that the falls are reviewed to analyze for trends and patterns. The most recent Minimum Data Set dated 6/7/07 indicates that R4 has moderately impaired	F 280		

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F 280	Continued From page 7 cognition for daily decision-making ability. R4 needs extensive assistance with all activities of daily living. 5. R3's most recent care plan dated 4/5/07 under "Safety Notes" indicates- "I'm at risk for falls due to weakness, poor decision-making abilities. I do utilize a wheelchair for mobility so please monitor my position and correct as needed. My goal is that I will be free from incidents for the next 3 months. "6/07 falls" The Incident Reports dated 3/3/07, 5/31/07, 6/9/07 and 6/24/07 indicate that R3 was found on the bedroom floor each of these times. No apparent injuries noted. The care guide does not address these falls and does not provide any new approaches/intervention to prevent future falls. There is no documentation to indicate the falls are reviewed to analyze for trends or patterns in order to figure out new interventions. The Minimum Data Set dated 4/23/07 indicates that R3 is has severely impaired cognition for decision-making. R3 needs extensive assist with activities of daily living. R3 has poor short and long term memory loss due to Alzheimer's disease. 6. R17's most recent care plan dated 5/17/07 under "Safety Notes" indicates- "I am at risk for falls related to age and increased confusion. My goal is to remain free from incident/injury for the next 3 months. The incident reports dated 4/24/07, 6/6/07 and 7/22/07 indicate that R17 has fallen 3 times while ambulating with her walker with the most recent fall causing a fracture to right and left side of	F 280		

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F 280	Continued From page 8 pelvis. The most recent care guide dated 5/17/07 does not address any falls and does not provide an approaches/interventions to prevent future falls. The care plan has not been updated after these falls. There is no documentation to indicate the falls are reviewed to analyze for trends or patterns in order to figure out interventions to prevent future falls. The Minimum Data Set dated 5/15/07 indicates that R17 has modified independence with decision-making ability-some difficulty in new situations only. Until the fall on 7/22/07, R17 was independent with ambulation, transferring, eating and set up help for hygiene.	F 280		
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to reposition and relieve pressure on the bony prominences of R2, 1 of 4 sampled residents identified with pressure ulcers. The facility failed to have a Dietary Assessment on admission on R2 who was admitted with 4 pressure areas to ensure that intake was adequate to promote the healing of the pressure ulcers.	F 314		8/1/07

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F 314	Continued From page 9 Findings include: R2's POS (Physician Order Sheet) dated July 2007 states R2 was admitted to the facility on 5/22/07 with a current diagnoses including Sepsis, Urinary Tract Infection, Congestive Heart Failure, Insulin Dependent Diabetes Mellitus, and Atherosclerotic Heart Disease. R2's Care Guide dated 7/16/07 states "I have multiple decubitus and stasis ulcers which I received while hospitalized. I have a stage 4 to my left heel, a stage 3 to my right heel, a stage 4 to my left elbow with undermining and 3 stage 2 to my coccyx. I have peripheral vascular disease...I am being seen and treated by the wound clinic..I am to be up for meals only but I tend to be non-compliant with this. I will stay up as long as I want to.....strongly encourage me to stay off my back." History and Physical dated 6/20/07 states that R2 had been admitted to the hospital for a UTI (Urinary Tract Infection) and that R2 had a fall on 4/2/07 wherein he suffered a spinal fracture. A review of R2's dietary section of his medical record shows that a dietary assessment was not completed by the Dietician until 7/17/07 approximately two months after admission. The evaluation section states: Labs show severe depletion of protein. CBC is abnormal (anemic)..D/C (discontinue) bid shake. Offer 2 cal. (Calorie) with med passes (60 cc's qid [four times daily]...continue LCS (Low concentrated sweets) diet...encourage high protein foods at each meal, including milk...Offer skim milk with all meals, and juice at meals. A sign was observed above R2's bed written by	F 314		

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F 314	Continued From page 10 Z3, Wound clinic doctor, which states: For buttock: "Limit sitting-30 min. (minutes) each meal. Rest of time reclined mostly on sides and 2 hours on back." On 7/23/07 at 12:30 p.m., R2 was observed in his room sitting upright in his wheel chair with his legs elevated. R2's spouse and a friend were present. R2 stated that he had been up since before breakfast or about 8:00 a.m. Z4 (family member) stated that he should be put to bed that he is "up too long." When asked if he wanted to go to bed, R2 stated, "I sure do. I am so tired." R2 stated that he had not been toileted since before breakfast nor had he been lifted to relieve pressure on his buttocks. At 1:05 p.m., E15, CNA came to answer R2's call light to go to the bathroom. E15 stated that R2 had been up since before breakfast. E15 took R2 down the hallway to the shower/toilet room per wheel chair, then he was lifted by the sit to stand lift and placed on the toilet with the assistance of E16, CNA. R2 had 2 open areas on the left buttock which had no dressing in place. E15 stated she was going to get the nurse to check on the wound. E4, Licensed practical Nurse/LPN, stated that the wounds in that area were to be treated only with Xenaderm and that they were not to have a dressing per the wound clinic orders. On 7/24/07 at 12:30 p.m., R2 was observed to be upright in the wheel chair with both legs elevated. R2 stated he had been up in the chair since before breakfast. R2 was placed back to bed at approximately 12:45. Observed dressing changes to bilateral heels and left elbow.	F 314		
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident	F 323		8/1/07

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F 323	Continued From page 11 environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to keep all resident accessible areas free of potentially hazardous chemicals. Findings include: During the general tour with E1 (Administrator) and E7 (Maintenance Supervisor) on 7/24/07 at approximately 11:15 AM to 11:30 AM, potentially hazardous chemical agents were found in unlocked areas as follows: - 1 gallon of disinfectant was noted in the unlocked, unattended Shower room #2 on the Skilled Hall in an open cabinet. The product posted a "Keep out of Reach of Children" warning on the label. - the unlocked upper cabinets in the unlocked South soiled utility room contained the following items: 1 bottle Plastic Polish #2 which posted a "Keep out of Reach of Children " warning on the label, and its Material Safety Data Sheet (MSDS) stated the following: "May cause respiratory irritation. Exposure to high concentrations may cause headache, dizziness, and nausea. Eye contact may cause burning and irritation. Skin contact is a possible route of entry. Prolonged or repeated skin contact may lead to drying, irritation, and dermatitis"; 2 bottles of Plexiglass Cleaner, whose MSDS stated: "May be mildly irritating to the eyes, nose, and throat. May cause mild skin irritation in certain individuals. Prolonged or repeated skin contact may lead to drying, irritation, and dermatitis"; 1 bottle of Liquid Cream Cleanser	F 323		

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F 323	Continued From page 12 which posted: "Corrosive. Skin and eye irritant. Keep out of Reach of Children"; and 1 bottle Bowl Cleaner which posted: "Danger. Corrosive. Concentrate causes eye and skin burns. Harmful or fatal if swallowed." A list of independently ambulatory residents with diagnoses of Alzheimer's Disease, Dementia, Confusion, etc. provided by E2 (Director of Nursing) at 1:30 PM on 7/24/07 indicated that there were currently 10 such residents living in the facility at this time.	F 323		
F 324 SS=K	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: A) Based on interview, observation and record review, the facility failed to develop and implement a system to collect and analyze data related to the number, types and frequency of falls to identify trends and patterns and failed to assess the root causes of the falls, failed to review and revise the care plan interventions to address the falls, failed to implement interventions to minimize the risks for falls and injuries and failed to monitor the residents to prevent recurring falls to minimize the risk for serious injury for 5 of 6 residents on the selected sample at risk for falls(R1,R3, R4, R8, R9) and for 1 resident (R17) not on the sample. Three of these residents (R4, R9 and R17) sustained fractures due to the falls This failure resulted in an Immediate Jeopardy.	F 324		8/1/07

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 324	Continued From page 13 While the Immediate Jeopardy was removed on 8/01/07, the facility remains out of compliance at severity level two. Additional time is needed to evaluate the implementation of revised policies and procedures and the effectiveness of these changes as well as inservices provided to staff. Findings Include: The facility's policy and procedure titled, "Falls-Clinical Protocol and Assessing Falls and Their Causes" states the following: "The physician will help identify individuals with a history of falls and risk factors for subsequent falling. In addition, the nurse shall assess and document/report vital signs, recent injury, Musculoskeletal function, change in cognition, Neurological status, pain, frequency and number of falls since last physician visit, precipitating factors, all current medications, all active diagnoses, the staff will document risk factors for falling, the physician will identify medical conditions affecting fall risk, staff will evaluate and document falls- falls should be categorized, staff and physician will monitor and document the individual's response to interventions intended to reduce falling-whether interventions are successful in preventing falling or if the individual continues to fall, the staff and physician will re-evaluate the situation." Under Policy Interpretation and Implementation--Prioritizing Approaches to Managing Falls and Fall Risk, #5 states, "If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped..."	F 324		

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	146099	A. BUILDING _____ B. WING _____	08/01/2007

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F 324	Continued From page 14 On 7/26/07 at 11:12 a.m., E1 (Administrator) stated that the attending physician does not help identify individuals with a history of falls or identify medical conditions affecting fall risk or monitor and document the individual's response to interventions. E1 stated that this is done by the nursing staff. E1 stated that falls are not discussed in the daily stand up meetings held every morning. On 7/26/07 at approximately 3:30PM, Z5 (Medical Director) was interviewed regarding the facility fall policy and the Quality Assurance Committee. Z5 stated that the falls are reported to the physician by telephone and the physician gives the order from the nurses observation and assessment of the resident. The fall committee meets monthly as does the quality assurance committee. The fall committee reports on the falls for the month. Possible reasons for the falls are discussed along with any interventions to be used. Z5 stated that the physician does not chart on the residents fall risk or response to interventions or the medications that may increase the risk for falls according to the facility policy. Z5 stated that the nurses do that charting. On 7/25/07 at 11:30 AM, E1 (Administrator) and E2 (Director of Nurses) indicated that all fall incidents are reviewed by a fall committee and by the Quality Assurance Committee which meets once a month. Recommendations are made to prevent further falls. E2 presented incident reports for the 7 residents on the sample that have fallen 30 times since the last survey. There was no additional information regarding an analysis of the number of repeated falls for each individual resident over a given period of time or trend analysis by hallway, location or shift.	F 324		

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F 324	Continued From page 15 Review of the incident reports and interview with E2 showed there is no evidence that the facility developed and implemented corrective action plans to address the number of falls occurring in the facility. The 30 individual fall investigation worksheets were reviewed. The "Recommendation/Interventions" section was left blank on all the incident worksheets. E1 stated that the Fall incident report is reviewed by the Restorative Nurse and the DON and then by the Safety Committee and the Quality Assurance committee monthly. 1. R9's July 2007 POS (Physician Order Sheet) states that R9 is 89 years old and has the diagnoses of weakness, Congestive Heart Failure, Atrial Fibrillation, Hypertension, Insulin Dependent Diabetes Mellitus, Atherosclerotic Heart Disease and has a previous Right hip fracture and repair. R9's medication regime includes Hydrocodone, 5/500 every 4-6 hours for pain. The Drug Information Handbook for Nursing 8th edition 2007 states that Hydrocodone can cause anxiety, dizziness, drowsiness, euphoria, lightheadedness and that it should be used with caution in the elderly. R9's most recent Care Guide (Plan) dated 5/1/07 states under "Safety Notes: I am at low risk for incidents." There are no interventions listed to prevent falls, nor are the falls that R9 has incurred listed in the Care Guide. R9's Admission diagnosis includes "Status post Hip Repair." R9's Care Plan states under "Social History: Because of weakness I needed to transfer to the health care center for more help.....I need the supervision of 1 with transfers." R9 had previously resided in the	F 324		

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F 324	Continued From page 16 Shelter Care section of the facility. R9's most recent MDS (Minimum Data Set) states that R9 needs 1 person physical assistance to toilet and transfer. On 7/25/07 at 1:10 p.m., R9 was being assisted to the toilet. R9 was able to stand while holding on to the grab bar in the bathroom with 1 person assist and the use of a gait belt. R1 needed to be cued as to what to do, example: "stand now; turn to your right now; you can sit down now." Facility Incidents list 6 falls between 9/20/06 and 6/20/07 for R9 as follows: 9/20/06 at 8:30 p.m., "Fell trying to transfer self.....occurred in the bathroom....reminded to call for help" 3/17/07 at 1:45 a.m., "Found on floor near closet." (No interventions noted.) 3/26/07 10:30 p.m. "Slid forward out of wheel chair...abrasions to bilateral (both) knees." 5/16/07 at 7:50 p.m. "Found on floor in dining room." 5/20/07 10:30 p.m. "On floor by bed." (Back Pain-X-ray showed L-4 compression fracture). 6/20/07 at 1:45 a.m. "Fell transferring self from wheel chair to bed...Put on body alarm." None of the above Incidents had any interventions listed except the last one which stated, "Put on body alarm." There were no interventions listed in R9's Care Guide (Plan). On 7/23/07 at the noon meal, R9 was observed to have a body alarm in use. 2. R1's July 2007, Physician Order Sheet states that R1 is 83 years old and lists the following diagnosis: Chronic Obstructive Pulmonary Disease, Bronchitis. R1's most recent full MDS	F 324		

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F 324	Continued From page 17 (Minimum Data Set) dated 3/28/07 also lists Insulin Dependent Diabetes Mellitus, Hypertension, Heart Disease, Cerebral Vascular Accident, and pneumonia. The MDS dated 5/24/07 states that R1 needs extensive 1 person assistance to transfer and toilet. Both MDS assessments state that R1 has an unsteady gait. R1's Most recent Care Guide (Plan) dated 4/30/07 states under "Safety Notes: I have a history of frequent falls with the most recent just since this admission to the health care center. I have had a decline in functional mobility with weakness and poor safety awareness. I have a personal alarm for added safety. If you hear it sounding, respond to it immediately (all). My goal is to remain free from injury from incident through the next review." No other interventions were noted in the care plan and none of the following 16 falls were documented. Facility Incidents list 16 falls for R1 between 3/5/07 and 7/16/07 as follows: 3/5/07 at 7:20 p.m. "Resident found laying on ..floor at the end of the bed...Complained of pain to bilateral shoulders...low blood sugar (41).....Number of Falls in the past 31-180: 13 until 11/14/06.....unwitnessed." 3/6/07 10:00 a.m. "Res. (resident) states he was getting out of chair to go to B.R. (bathroom) fell on bottom. Intervention: Cont. (Continue) to remind him to use call light....unwitnessed." 3/7/07 6:00 a.m. "Res. states he had walked to B.R. with walker and walked back to chair and rolled on to the floor....Unwitnessed." 3/8/07 4:20 a.m. "Res. up in B.R. brushing teeth lost balance fell to floor.....unwitnessed." 3/9/07 1:00 a.m. "Res up amb. (ambulating) I	F 324		

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F 324	Continued From page 18 (independently) to BR(bathroom) lost balance fell backwards to floor. AROM (active range of motion to all extremities. small laceration noted to L side of head by ear.....unwitnessed." 3/10/07 5:00 a.m. "Res. attempting to get up to go to BR and slid to floor no visible injuries noted AROM (active range of motion) to all extremities.....unwitnessed." 3/10/07 4:30 p.m., "Resident found on floor going to the bathroom. Able to move all extremities. Did not hit head. No new injuries noted." 3/10/07 9:30 p.m., "Resident attempted to get self up to bathroom-found lying on back with t.v. lying/resting on Rt. side neck. Able to move all extremities." (body diagram shows bruising to left neck area and abrasion to the right back, rib area). 4/26/07 10:00 p.m. "Resident found on floor next to bed on pad. Only injury was a 1 cm. (centimeter) X 1.5 cm. skin tear on R.(right) knee. Laying on back. Able to move all extremities. Neuros WNL (within normal limits). Environmental: mattress pad on floor. Body alarm on.....unwitnessed." 4/29/07 8:15 a.m. "Res was taken into BR and put on toilet. Call light handed to him. Turned light on and before aide got in there he was sitting on floor....more confused at times. Occurred in Dining room bathroom.....witnessed." 5/8/07 7:15 p.m. "Asking CNA (certified nurse aide) to help me with another resident when finished with (R1). CNA left to go get him a gown and asked (R1) to wait for him. Before CNA could leave (R1) stood and fell hitting R (right) forehead on cabinet....red area to forehead R side....Bump R forehead....witnessed." 5/28/07 9:30 a.m. "Resident attempted to transfer self from w/c to bed and slid to floor landing on gluteus....No apparent injury....pressure	F 324		

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F 324	Continued From page 19 alarm....unwitnessed." 6/3/07 11:00 a.m. "Res. was trying to walk from w/c to bed with walker when he lost his balance and fell to the floor, landing on his left side.....abrasion/bruise R side of face...pressure alarm.....unwitnessed." 6/10/07 12:25 p.m....."Dining room....res. sitting at table eating. (w/c locked when he was brought in) when he started to lean forward and w/c started to move backwards and he then fell forward and hit floor. Comments/Concerns....had been known to unlock wheel chair....he had a laceration on his forehead, and skin tears on the back of L hand. His breathing was labored, his eyes fixed and glazed over. Not responding to verbal stimuli.....Sent to local hospital." 6/12/07 8:30 p.m. "Resident tried to get up on his own without asking for help and fell on R side. No injury except reopened two scabs on R elbow. cleansed covered with (non adherent) dressing and roll gauze. Neuro's.....unwitnessed....no other interventions." A Fall Risk Assessment was attached to this Incident log with no date, but included a fall risk score of 22 (10 or above represents HIGH RISK) 7/16/07 1:30 a.m. "Resident attempted to walk to w/c falling on bedside mat. Res hit occipital portion of head on bed small laceration noted. B. (blood) sugar 198 @ time of fall. Neuro's....unwitnessed....interventions--(none)." 3. According to the July 2007 physician order sheet, R4 is a 105-year-old-female admitted 4/13/05 with diagnoses of Atrial Fibulation, and Gastric Esophogeal Reflux Disease. On 9/13/06 R4 had an Open Reduction Internal Fixation of the Right Hip due to a fall in the facility. The Minimum Data Set dated 6/7/07 indicates	F 324		

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F 324	Continued From page 20 that R4's cognition is moderately impaired with short term memory loss. R4 has a history of falls in the past 30 days and 31- 180 days with hip fracture. R4 requires extensive assist with transfer, ambulation, and hygiene/bathing. The Resident Assessment Protocol -Falls- "Resident is at risk for further falls related to confusion due to diagnosis of senile dementia with poor safety awareness and unsafe decisions and not understanding her physical limitations. Personal alarm is used for safety. Will proceed with plan of care prevention." The Care Guide dated 6/12/07- Safety Notes: "I'm at risk for falls due to poor safety awareness, impaired cognition, behavior problems and a fall in the last 6 months resulting in hip fracture. There is a night light in my room and the staff leaves the bathroom door open for me. My goal is that I will be free from injury related to incidents for the next 3 months. The nurse will report all incidents to my doctor and family. They will record each incident and evaluate for a common cause that may prevent future incidents. Remind me that I am unable to get up per myself and that I need to call for assistance. Ensure the call light is within easy reach at all times that I am in my room. Be sure personal alarm is used at all times for added safety. My last fall was 5/2007." The Incident Report dated 5/5/07 revealed that "R4 fell at 3:30 PM and was found sitting on the floor in the room in front of the wheelchair. R4 was vague as to what happened. Denies discomfort. No lacerations, contusions or abrasions noted." According to this document this is the 3rd fall in the past 31-180 days. The Recommendations/Intervention section is blank.	F 324		

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F 324	Continued From page 21 The other Incident Report that was presented was dated 6/12/07 at 1:30 PM, "(R4) was found sitting on bottom- puddle of urine. Alerted by maintenance. The physician was notified on 6/14/07 while doing rounds in the facility. The Recommendations/Interventions section is blank. The care guide does not address the falls and provide new interventions to prevent future falls. There is no documentation to indicate that the falls are reviewed to analyze for trends and patterns. 4. The current physician's order sheet indicates that, R3 is a 75-year-old-female with diagnosis of Alzheimer's Dementia Gastro-Esophogeal Reflux Disease and Peripheral Vascular Disease. The Minimum Data Set dated 4/23/07 indicates that R3's cognition is severely impaired. R3 needs extensive assist with transfers, dressing, hygiene/bathing and ambulation. The Care Guide dated 4/5/07 indicates that R3 is "unable to ambulate, I utilize the wheelchair for mobility propelled by others. I need extensive assist with transfers to and from the chair and bed." Safety Notes: "I'm at risk for falls due to weakness, poor decision making abilities. I do utilize a wheelchair for mobility so please monitor my position and correct as needed. My goal is that I will be free from incidents for the next 3 months." The Incident Report dated 3/5/07 indicates that at 10:30 PM, "R3 was found lying on her side in the room on the floor pad. Resident appears like she rolled out of bed. Resident is confused, unable to say how she fell." The Recommendation/Interventions section is blank. The Care Guide does not address this fall or	F 324		

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F 324	Continued From page 22 provide any interventions to prevent future falls. The incident report dated 5/31/07 indicates that a Certified Nurses Aid found R3 at 10:50 PM "sitting on knees on the mattress below her bed, her hands and head was resting on the bed." The Recommendation/Interventions section of the report is blank. The Care Guide does not address this fall. The Incident Report dated 6/9/07 indicates that "R3 was found kneeling on floor next to bed at 12:15 Am next to bed on floor pads. Old blister that had broken was dressed." The Recommendation/Intervention section of this report is blank. The Care Guide does not address this fall. The Incident Report dated 6/24/07 indicates that at 2:30 AM, "R3 was found on mattress on floor. No apparent injuries at this time. ROM is WNL (range of motion is within normal limits) for resident, denies pain/discomfort. Protocol for unwitnessed fall initiated, assisted to bed with 2 assist without difficulty." The Care Guide does not address the falls or implement any interventions to prevent further falls. There is no documentation to indicate that the falls are reviewed to analyze for trends or patterns to prevent further falls. 5. R8's July 2007 POS states that she has the diagnoses of Non-Insulin Dependent Diabetes Mellitus, Hypertension, Osteopenia, Parkinson's Disease, Polyradiculopathy, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Arthritis, Chronic Renal Failure,	F 324		

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F 324	Continued From page 23 Dehydration and Urinary Tract Infections. "The MDS dated 7/11/07 states that R8 "requires extensive assistance of 2 with stand lift with transfers and toileting, extensive assist of 1 for bed mobility, ADL's (Activities of daily living) ambulation with w/w (wheeled walker)....displays an unsteady gait, and poor safety awareness due to the aging process and diagnosis of dementia....recent hospitalization of volume depletion, UTI and acute kidney injury.....has had falls in past 30 days and 31-180 days and is at risk for further falls". MDS dated 7/11/07 states that R8 needs extensive assistance of 2 persons for transfers, toileting and ambulation and extensive assistance of 1 person for bed mobility." R8's Care Guide dated 7/17/07 states that she "needs extensive assistance of two and gait belt for all transfers (nsg). The Care guide states that R8 has a "history of falls and that R8 has a body alarm when in the w/c (wheel chair) and a sensor pad when in bed." Facility Incident Reports list 2 falls for R8 between February 12th and April 15, 2007. "2/12/07 10:45 p.m., Res. was noted sitting on buttock in front of w/c on side of bed. PROM (passive range of motion) done with very little difficulty. Res up 2:1 assist to bed. No complaints of pain at this time....Under Recommendations/Interventions: remind to ask for help. To use call light.....number of falls in past 30 days: 2." "4/5/07 12:10 a.m. P/A (personal alarm) sounded. Found on floor in sitting position leaning back against bed. Verbally responsive. Assisted back into bed with 2 assist and gait belt....no recommendations or interventions."	F 324		

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F 324	Continued From page 24 The Care Guide dated 7/17/07, does not list these falls nor provide any new interventions to prevent future falls. 6. The Physician Order Sheet dated 7/07 indicates that R17 is a 101-year-old-female with diagnoses of Congestive Heart Failure, Hypertension, Hypokalemia, Gastroesophageal Reflux Disease, Colitis, Hypokalemia, Coronary Insufficiency and Transient Ischemic Attacks. R17's Minimum Data Set dated 5/15/07 indicates that R17's cognitive skills for daily decision-making is modified independence with some difficulty in new situations only. R17 transfers independently, ambulates independently with walker, dresses independently and maintains personal hygiene with supervision and set up help only. R17's Fall Risk Assessment dated 5/15/07 indicates that R17 is scored at high risk for falls. The incident report dated 4/27/07 at 8:30AM indicates that R17 fell in the dining room with her walker. "Stumbled and fell on buttocks. No apparent injury." The Fall investigation Worksheet states that R17 just lost her balance when her walker caught on someone else's chair. The Recommendation/ Intervention section is left blank. The incident report dated 6/6/07 at 9:00PM states that R17 was in her room trying to get up and slid to the floor on her bottom. No apparent injuries. The Fall Investigation Worksheet Recommendation/Interventions section is left blank. The care plan dated 5/17/07 under the Mobility	F 324		

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F 324	Continued From page 25 section it states: "Ambulating: I'm up ab lib with the walker. Since I have had a recent room change please give me verbal cues in the right direction-I have a tendency to go back to my old room. I am able to transfer myself. I am able to reposition myself in the chair and bed. I do not use side rails. I use the wheeled walker while ambulating. Pt screens me quarterly for any possible needs" Under the Safety Notes section it states "I am at risk for falls related to age and increased confusion. My goal is to remain free from incident/injury for the next three months." The care plan does not address these falls or provide any interventions to prevent future falls. There is no documentation to indicate that the falls are reviewed to analyze for trends and patterns. The Immediate Jeopardy situation was identified on 7/25/07 at 2:10 p.m. The Immediate Jeopardy was determined to have begun on 4/27/07 when the facility failed to investigate the fall of R17 and failed to put into place individualized interventions on R17's care plan that would assist staff in preventing further falls. The Administrator was notified of the Immediate Jeopardy on 7/25/07 at 2:20 p.m. The surveyor confirmed through interviews, observations, and record review that the facility took the following actions to remove the Immediate Jeopardy. ADMISSION PROCEDURE TO BE COMPLETED UPON ADMISSION 1)INITIAL NURSING ASSESSMENT 2)FALLS RISK ASSESSMENT: IF IDENTIFIED AS A HIGH RISK FOR FALLS, A PERSONAL ALARM WILL BE APPLIED PENDING	F 324		

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F 324	Continued From page 26 FURTHER REVIEW. 3)BEHAVIOR ASSESSMENT 4)ELOPEMENT ASSESSMENT 5)BLADDER ASSESSMENT 6)PAIN ASSESSMENT 7)BRADEN ASSESSMENT 8)INTERIM PLAN OF CARE 9)ADMISSION NURSING NOTE REVIEWED ADMISSION PROCEDURE ON 7/25/07 REVISED 7/25/07 REVISION EFFECTIVE 7/25/07 THAT A PERSONAL ALARM WILL BE APPLIED TO RESIDENT IF IDENTIFIED AS HIGH RISK FOR FALLS UPON ADMISSION. FALL CLINICAL PROTOCOL REVIEWED AND REVISED 7/25/07 (attachment A). REVIEWED AND REVISED INCIDENT REPORT FORM 7/25/07. (attachment B) REPORT WILL BE PLACED IN INCIDENT REPORT BOX UPON COMPLETION. EFFECTIVE 7/26/07: INCIDENT REPORT WILL BE DISCUSSED AT MORNING Q.A. MEETING WITH INTERVENTIONS TO BE DISCUSSED TO PREVENT FURTHER FALLS. EFFECTIVE 7/26/07: CARE PLAN COORDINATORS WILL UPDATE CARE PLAN AFTER DAILY Q.A. MEETING WITH FALL DATES AND INTERVENTIONS AFTER MORNING Q.A. MEETING AND STAFF WILL BE NOTIFIED IN WRITING WITH INSERVICE SIGN IN SHEET FOR ALL THREE SHIFTS ANY/ALL INTERVENTIONS IMPLEMENTED. REHAB NURSE WILL COMPLETE Q.A. AUDIT FORM. (attachment C).	F 324		

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F 324	Continued From page 27 REHAB NURSE TO COMPLETE RESIDENT FALL TRACKING LOG AFTER EVERY FALL EFFECTIVE 7/25/07. (attachment D). EFFECTIVE 7/26/07: REHAB NURSE INSERVICED ON NEW POLICY AND AUDIT FORM. AUDIT FORM TO BE COMPLETED AFTER RECEIVING INCIDENT FORM EFFECTIVE 7/25/07. FALL RISK ASSESSMENT WAS REVIEWED AND REVISED ADDING: IF RESIDENT IS A HIGH RISK FOR FALLS UPON ADMISSION, A PERSONAL ALARM WILL BE APPLIED IMMEDIATELY PENDING FURTHER REVIEW. (attachment E). RESIDENTS IDENTIFIED ON SURVEY WILL HAVE THEIR CARE PLAN REVIEWED AND REVISED WITH FALL PREVENTION INTERVENTIONS BY 7/30/07. REMAINDER OF CARE PLANS WILL BE REVIEWED AND REVISED WITH FALL PREVENTION INTERVENTIONS AS INDICATED BY 8/3/07. INTERIM PLAN OF CARE REVIEWED AND REVISED. (attachment F). INTERIM CARE PLAN (COPY) WILL BE POSTED IN RESIDENTS ROOM ON BULLETIN BOARD FOR STAFF TO REFER TO EASILY. INSERVICE TO BE DONE ON 7/27/07 AND 8/1/07 WITH TOPICS: COMPLETION OF UPDATED INCIDENT REPORT FALLS INVESTIGATION FORM UPDATING CARE PLAN WITH FALL INTERVENTIONS INTERIM CARE PLAN REVISION	F 324		

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F 324	Continued From page 28 FALLS RISK ASSESSMENT REVISION (attachment G). CARE PLAN CHANGES WILL BE ADDRESSED AT THE 8/1/07 INSERVICE WITH THE ENTIRE NURSING STAFF (NURSES, C.N.A. ' S, ETC. B) Based on observation, record review, and interviews, the facility failed to monitor the whereabouts of 1 of 13 sampled residents (R17). R17 left the facility without staff knowledge. R17 was found lying on the driveway of the facility with a fractured pelvis by an off duty staff member who lives near the facility. Findings include: A facility incident report dated 7/23/07 which was sent to the State Agency indicated that R17 was found outside the facility at 7 PM on 7/22/07 in the driveway lying on her side with her walker. The report stated that R17 was assessed by facility nurses at the time and sent to the emergency room at the local hospital. R17 was returned to the facility later that night at 10:45 PM with a diagnosis of a fractured pelvis. R17's hospital radiology report dated 7/22/07 indicated that R17's pelvis was fractured at the right and left inferior and superior pubic rami. R17's nursing notes for 7/22/07 at 10:40 PM indicated that the hospital called to inform the facility nurse that R17 sustained multiple fractures of the right and left pelvis and was to be placed on bed rest. Darvocet N100- 1 to 2 tabs every 4 to 6 hours as needed for pain was ordered. R17's nursing notes at 10:45 PM indicated that the resident was returned to the facility in a state of "normal confusion" and in "no	F 324		

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F 324	Continued From page 29 acute distress." The facility's in-house incident report dated 7/22/07 indicated that R17's fall outside the building was witnessed by an off duty nurse aide, E8. Interview with E8 at 3 PM on 7/24/07 indicated that she lives across the street from the facility, and around suppertime on 7/22/07 she observed R17 with her walker ambulating in the facility's driveway. E8 stated that it was peculiar for R17 to be outside, so she went over to the scene to assist R17. E8 also stated that R17 fell to the ground before she could get to her. E8 reported that R17 was confused when E8 tried to talk to her, but that she said she was trying to "go home." E8 stated that R17 was in a lot of pain at the time. E8 said that she told someone in the area to get a nurse and that a nurse came out with 2 aides to assist R17. Interview with nurse E10 on 7/25/07 at 2:40 PM indicated that she was working the hall where R17 resided on the evening of 7/22/07. E10 stated that when she went on supper break at approximately 6:00 to 6:15 PM she noticed R17 sitting by the nurses' station resting. E10 said that when she got back from break, she learned that R17 had fallen outside. E10 stated that nurse E11 had brought R17 back into the building just before she got off break, and that she (E10) then proceeded to complete an incident report. E10 also stated that she was aware of one other incident that occurred in May this year when R17 had gotten out of the facility unattended. E10 stated that she herself assisted R17 back inside that time. Interview with nurse E11 on 7/26/07 at 9:45 AM indicated that on the evening of 7/22/07 at	F 324		

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F 324	Continued From page 30	F 324		

approximately 6:20 PM she received 2 telephone calls, one from E8, reporting to her that R17 was outside in the driveway. E11 said that by the time she got outside with the nurse aides, R17 was down on her side. E11 stated that R17 was in pain at that time, but was able to get up off the ground. E11 was unable to walk at that point, so they placed R17 in the seat of her walker. E11 said they then wheeled R17 to her room and transferred her to a bedside chair. E11 said that when R17 was then assessed, her range of motion was poor. E11 reported that she called for an ambulance about 6:30 PM, and that R17 left for the hospital at 6:40 to 6:45 PM. E11 further stated that she was unaware of previous attempts by R17 to leave the building, and that R17 was not wearing an electronic monitoring device at the time. E11 also stated that just before the incident, R17 was alert, yet forgetful.

An interview was attempted with R17 at approximately 1:45 PM on 7/25/07, but the resident was very confused at the time and was not oriented to person. R17 also did not recognize relative Z1 in the room at the time. Z1 stated that R17 has been much more confused since the fall the other day.

R17's MDS (Minimum Data Set) done before her fall indicated R17 was independent with ambulation and could make decisions with assistance needed in new situations only. Since the fall, R17 was observed to be confused and in need of total staff assistance for all activities of daily.

R17's Care Guide dated 5/17/07 indicated that R17 is 101 years of age with diagnoses including arthritis and osteoporosis. The Guide also stated

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that R17 is forgetful, and had an electronic monitoring device to alert staff of any independent attempts to go outside unaccompanied until 5/22/07. At that time, the Guide was revised to indicate that the device was removed, with instruction to staff to monitor R17 for whereabouts. The Guide also indicated that R17 is at risk for falls "related to age and increased confusion."

An Elopement Assessment for R17 completed on 5/15/07 indicated that the resident scored as a "Low Risk Elopement" to be placed on a "Caution Elopement List".

Nursing Notes for R17 indicated in charting for 5/2/07 at 5:45 PM that an electronic monitoring device was placed on the resident's ankle since the resident was trying to leave due to increased confusion related to a recent room change. An entry at 9:50 PM that same day indicated that the resident was found outside wandering in the driveway, confused about her whereabouts. The entry also included: "all other staff alerted to watch her (R17) closely." Charting for 5/22/07 at 2:20 PM stated that the monitoring device/transponder was removed at that time and "will continue to monitor."

Interview with E4 (Care Plan Coordinator) on 7/25/07 at approximately 2 PM indicated that she understood that the monitor was taken off of R17 in May because Z1 requested that it be removed.

Interview with Z1 on 7/25/07 at approximately 2:30 PM indicated that he wanted the monitor removed because R17 told him it bothered her leg. However, Z1 also stated that at the time he requested the monitor be removed he was not

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F 324	Continued From page 32 aware that R17 had been making attempts to exit the building. Z1 stated that R17's health had been good up until the time of this fall outside. C) Based on observation, record review, and interview, the facility failed to transfers 2 of 13 sampled residents (R6, R8) in a safe manner as stated on their Care Guides. Findings include: 1). R6's Care Guide dated 5/7/07 states: "I need extensive assist of two with all transfers with the mechanical lift." 0n 7/24/07 at 1:30 p.m., R6 was observed to be transferred from her high back wheel chair to the bed per E13 and E14, CNA's. It was noted that R6 does not bear weight well. Once E13 and E14 had leaned R6 against the bed, they each placed an arm under R6's legs to lift her into the bed. Due to the height of the bed, the CNA's had a difficult time getting R6 into the bed. When asked why they did not lower the bed so they could just pivot R6 and sit her on the bed, they stated that the bed won't go any lower. The bed had a U shaped mattress on it to prevent R6 from rolling from the bed. According to R6's MDS dated 6/25/07, she weighs 111 pounds. 2.) R8's Care Guide states R8 "needs extensive assistance of two and gait belt for all transfers." On 7/24/07, at 10:30 a.m., E8, CNA (Certified Nurse Assistant), transferred R8 from her bed to the wheel chair and then to the toilet using a gait belt. After R8 finished going to the toilet, R8 transferred her to the wheel chair and then to the bed. E8 had a difficult time trying to pull R8 up in the bed without any other assistance.	F 324		
F 325 SS=D	483.25(i)(1) NUTRITION	F 325		8/1/07

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F 325	Continued From page 33 Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interview, the facility failed to provide dietary assessments and interventions for R1, R9, and R2, 3 of 4 residents identified with nutritional concerns. R9 lost 30 pounds with no interventions or assessment. R1 lost 17.5 pounds in three months. R2 was admitted with 4 pressure areas, anemia and protein deficiency with no dietary assessment for 2 months after admission. Findings include: 1. POS (Physician Order Sheet date July 2007, states that R9 was admitted to the facility on 4/1/05. The Dietary Assessment dated 10/18/04 was done when R9 was residing in the shelter care section of the facility. This assessment stated that R9 was consuming between 75-100 % of his meals. This assessment states that R9 has the diagnosis of diabetes, hypertension, Congestive Heart Failure, and weakness. It listed R9's weight as 141 pounds. On 7/23/07, at approximately 2:30 p.m., E2, Director of Nurses stated that this is the only dietary assessment that had been done. According to MDS (Minimum Data Set) dated 6/30/06 states that R9 had a weight of 154 pounds and the MDS from 4/30/07 shows a	F 325		

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F 325	Continued From page 34 weight of 124 pounds for a loss of loss of 30 pounds in 6 months. Doctors orders dated 5/12/07 show that R9 was placed on 2 Cal.(Calorie) supplement Med Pass TID (three times a day). There were no orders, dietary recommendations, dietary evaluations or interventions during this time when R9 lost 30 pounds. A dietary assessment was conducted on 7/23/07 with the following comments by the dietician: Wt. (weight) down 10% in last 90 days....current wt. is 128.4. Wt. is below suggested weight range...intake is less than 50%....ss(sliding scale) insulin for glucose control; diuretics which are K+ (Potassium) wasting. Calcium with vitamin D supplement and ( ) which requires consistent Vit. C. intake. Interventions: "Continue to encourage good nutrition and adequate intake to maintain. Continue 2 cal supplement 60 ml. (milliliter) TID (3 x's daily); assist at meals as needed; snacks PRN (as desired); Fluids PRN to meet needs greater than 7 cups /day; notify physician of significant weight change." R9's Medication assessment show that R9 is not currently on a Calcium + D supplement or Vitamin C. In the above interventions, there is no mention of ordering these supplements. 2. R1's Vital Sign records show that on February 27, 2007, R1 weighed 124.5 pounds. No weight is recorded for March. April 26, 2007 weight is documented as 112 pounds and May 11, 2007 it is documented as 107 or 17.5 pound wt. loss in 3 months. This is a 14% weight loss in 3 months.	F 325		

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F 325	Continued From page 35 No dietary assessment had been done regarding this weight loss, nor has there been any interventions with the physician or dietician. On 7/30/07, E3, Care Plan Coordinator was requested to provide a dietary assessment for R1. On 7/31/07 an assessment was faxed to the regional office which was done on 7/31/07. This assessment conducted on 7/31/07 states the following: "Weight is 80% of lower end of IBW (Ideal Body Weight), BMI (Body Mass Index) indicates under wt. status. Resident has lost 14 pounds since from wt. of 125 (1/23/07) to present wt. of 111.6 pounds-11% decrease in 180 days. Recommend to continue mechanical soft LCS (low concentrated sweets) with honey thick liquids. Give honey thick milk with each meal. Continue with fortified foods for additional calories. Offer thickened liquids between meals to enc. (encourage) adequate fluid intake. Bedtime snack, magic cup, fruit loops daily. Weekly weights. report wt. loss/gain. Notify physician of significant wt. change. Monitor intake daily". This assessment also states that R1 had a blood glucose of 694 on 5/25/07 and an elevated BUN, creatinine and decreased sodium. On 7/31/07 at 1:45 p.m., E1, Administrator was requested to provide any new orders for this resident Per conversation at 2:10 p.m. there was no new orders. 3. R2's POS (Physician Order Sheet) dated July 2007 states R2 was admitted to the facility on 5/22/07. Current diagnoses from the July 2007 POS includes Sepsis, Urinary Tract Infection, Congestive Heart Failure, Insulin Dependent Diabetes Mellitus, and Atherosclerotic Heart Disease. R2's Care Guide dated 7/16/07 states	F 325		

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F 325	Continued From page 36 "I have multiple decubitus and stasis ulcers which I received while hospitalized. I have a stage 4 to my left heel, a stage 3 to my right heel, a stage 4 to my left elbow with undermining and 3 stage 2's to my coccyx. I have peripheral vascular disease...I am being seen and treated by the wound clinic..I am to be up for meals only but I tend to be non-compliant with this. I will stay up as long as I want to.....strongly encourage me to stay off my back." History and Physical dated 6/20/07 states that R2 had been admitted to the hospital for a UTI (Urinary Tract Infection) and that R2 had a fall on 4/2/07 wherein he suffered a spinal fracture. A review of R2's dietary section of his medical record shows that a dietary assessment was not completed by the Dietician until 7/17/07. The evaluation section states: Labs show severe depletion of protein. CBC is abnormal (anemic)..D/C (discontinue) bid shake. Offer 2 cal. (Calorie) with med passes (60 cc's qid [four times daily]...continue LCS (Low concentrated sweets) diet...encourage high protein foods at each meal, including milk...Offer skim milk with all meals, and juice at meals.	F 325		
F 456 SS=F	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain the 3 door reach-in cooler/freezer in the dietary at 41 degrees Fahrenheit (F) or below; maintain the	F 456		8/1/07

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F 456	Continued From page 37 dietary range hood and associated fire suppression system in a clean, operating condition; maintain the walk-in freezer in a good operating condition; and maintain all vacuum breakers in a good condition. Findings include: During the dietary tour with E5 (Director of Special Projects) on 7/23/07 from approximately 10:30 AM to 11 AM, the following problems were noted: - The internal thermometer for the 2 refrigerator compartments of the 3 door reach-in cooler/freezer registered 50 degrees F. Internal temperatures of fried chicken and dressing stored inside the refrigerator unit were 50 degrees and 51 degrees F, respectively, on the digital metal stem thermometer. E5 stated that all food stored in the unit would be discarded immediately. Review of an inventory list of food in the unit provided by E5 indicated that assorted juices, bread dressing, cheese, milk, assorted meats, eggs and rice were in the unit at the time. - The range hood was greasy and linty on the inside surfaces, and a hand towel was noted wrapped around one of the spray nozzles (located over the tilt skillet) on the piping for the fire suppression system inside the hood. When E6(chef) was interviewed at approximately 10:50 AM as to why the towel was there, E6 said that a dietary staff member put the towel over the nozzle last week because they thought the nozzle was leaking. When the towel was removed by staff, no leakage was noted from the nozzle.	F 456		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 38 LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b)6) 300.1220b)2) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 assessment and plan of care. 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. b)6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All	F9999		

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F9999	Continued From page 39 nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations are not met, as evidenced by the following:	F9999		

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F9999	Continued From page 40 Based on interview, observation and record review, the facility failed to develop and implement a system to collect and analyze data related to the number, types and frequency of falls to identify trends and patterns and failed to assess the root causes of the falls, failed to review and revise the care plan interventions to address the falls, failed to implement interventions to minimize the risks for falls and injuries, and failed to monitor the residents to prevent recurring falls to minimize the risk for serious injury for 5 of 6 residents on the selected sample at risk for falls(R1,R3, R4, R8, R9), and for 1 resident (R17) not on the sample. Two of these residents (R4, R9) sustained fractures due to the falls Findings Include: The facility's policy and procedure titled, "Falls-Clinical Protocol and Assessing Falls and Their Causes" states the following: "The physician will help identify individuals with a history of falls and risk factors for subsequent falling. In addition, the nurse shall assess and document/report vital signs, recent injury, Musculoskeletal function, change in cognition, Neurological status, pain, frequency and number of falls since last physician visit, precipitating factors, all current medications, all active diagnoses, the staff will document risk factors for falling, the physician will identify medical conditions affecting fall risk, staff will evaluate and document falls- falls should be categorized, staff and physician will monitor and document the individual's response to interventions intended to reduce falling-whether interventions are successful in preventing falling or if the individual continues to fall, the staff and physician will	F9999		

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F9999	Continued From page 41 re-evaluate the situation." Under Policy Interpretation and Implementation--Prioritizing Approaches to Managing Falls and Fall Risk, #5 states, "If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped..." On 7/26/07 at 11:12 a.m., E1 (Administrator) stated that the attending physician does not help identify individuals with a history of falls or identify medical conditions affecting fall risk or monitor and document the individual's response to interventions. E1 stated that this is done by the nursing staff. E1 stated that falls are not discussed in the daily stand up meetings held every morning. On 7/26/07 at approximately 3:30PM, Z5 (Medical Director) was interviewed regarding the facility fall policy and the Quality Assurance Committee. Z5 stated that the falls are reported to the physician by telephone and the physician gives the order from the nurses observation and assessment of the resident. The fall committee meets monthly as does the quality assurance committee. The fall committee reports on the falls for the month. Possible reasons for the falls are discussed along with any interventions to be used. Z5 stated that the physician does not chart on the residents fall risk or response to interventions or the medications that may increase the risk for falls according to the facility policy. Z5 stated that the nurses do that charting. On 7/25/07 at 11:30 AM, E1 (Administrator) and E2 (Director of Nurses) indicated that all fall	F9999		

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F9999	Continued From page 42 incidents are reviewed by a fall committee and by the Quality Assurance Committee which meets once a month. Recommendations are made to prevent further falls. E2 presented incident reports for the 7 residents on the sample that have fallen 30 times since the last survey. There was no additional information regarding an analysis of the number of repeated falls for each individual resident over a given period of time or trend analysis by hallway, location or shift. Review of the incident reports and interview with E2 showed there is no evidence that the facility developed and implemented corrective action plans to address the number of falls occurring in the facility. The 30 individual fall investigation worksheets were reviewed. The "Recommendation/Interventions" section was left blank on all the incident worksheets. E1 stated that the Fall incident report is reviewed by the Restorative Nurse and the DON and then by the Safety Committee and the Quality Assurance committee monthly. 1. R9's July 2007 POS (Physician Order Sheet) states that R9 is 89 years old and has the diagnoses of weakness, Congestive Heart Failure, Atrial Fibrillation, Hypertension, Insulin Dependent Diabetes Mellitus, Atherosclerotic Heart Disease, and has a previous Right hip fracture and repair. R9's medication regime includes Hydrocodone, 5/500 every 4-6 hours for pain. The Drug Information Handbook for Nursing 8th edition 2007 states that Hydrocodone can cause anxiety, dizziness, drowsiness, euphoria, lightheadedness and that it should be used with caution in the elderly. R9's most recent Care Guide (Plan) dated 5/1/07 states under "Safety Notes: I am at low risk for	F9999		

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F9999	Continued From page 43 incidents." There are no interventions listed to prevent falls, nor are the falls that R9 has incurred listed in the Care Guide. R9's Admission diagnosis includes "Status post Hip Repair." R9's Care Plan states under "Social History: Because of weakness I needed to transfer to the health care center for more help.....I need the supervision of 1 with transfers." R9 had previously resided in the Sheltered Care section of the facility. R9's most recent assessment states that R9 needs 1 person physical assistance to toilet and transfer. On 7/25/07 at 1:10 p.m., R9 was being assisted to the toilet. R9 was able to stand while holding on to the grab bar in the bathroom with 1 person assist and the use of a gait belt. R1 needed to be cued as to what to do, example: "stand now; turn to your right now; you can sit down now." Facility Incidents list 6 falls between 9/20/06 and 6/20/07 for R9 as follows: 9/20/06 at 8:30 p.m., "Fell trying to transfer self.....occurred in the bathroom....reminded to call for help" 3/17/07 at 1:45 a.m., "Found on floor near closet." (No interventions noted.) 3/26/07 10:30 p.m. "Slid forward out of wheel chair...abrasions to bilateral (both) knees." 5/16/07 at 7:50 p.m. "Found on floor in dining room." 5/20/07 10:30 p.m. "On floor by bed." (Back Pain-X-ray showed L-4 compression fracture). 6/20/07 at 1:45 a.m. "Fell transferring self from wheel chair to bed...Put on body alarm." None of the above Incidents had any interventions listed except the last one which stated, "Put on body alarm." There were no	F9999		

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F9999	Continued From page 44 interventions listed in R9's Care Guide (Plan). On 7/23/07 at the noon meal, R9 was observed to have a body alarm in use. 2. R1's July 2007, Physician Order Sheet states that R1 is 83 years old and lists the following diagnosis: Chronic Obstructive Pulmonary Disease, Bronchitis. R1's most recent full assessment dated 3/28/07 also lists Insulin Dependent Diabetes Mellitus, Hypertension, Heart Disease, Cerebral Vascular Accident, and Pneumonia. The assessment dated 5/24/07 states that R1 needs extensive 1 person assistance to transfer and toilet. Both assessments state that R1 has an unsteady gait. R1's Most recent Care Guide (Plan) dated 4/30/07 states under "Safety Notes: I have a history of frequent falls with the most recent just since this admission to the health care center. I have had a decline in functional mobility with weakness and poor safety awareness. I have a personal alarm for added safety. If you hear it sounding, respond to it immediately (all). My goal is to remain free from injury from incident through the next review." No other interventions were noted in the care plan and none of the following 16 falls were documented. Facility Incidents list 16 falls for R1 between 3/5/07 and 7/16/07 as follows: 3/5/07 at 7:20 p.m. "Resident found laying on ..floor at the end of the bed...Complained of pain to bilateral shoulders...low blood sugar (41).....Number of Falls in the past 31-180: 13 until 11/14/06.....unwitnessed." 3/6/07 10:00 a.m. "Res. (resident) states he was getting out of chair to go to B.R. (bathroom) fell	F9999		

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F9999	Continued From page 45 on bottom. Intervention: Cont. (Continue) to remind him to use call light....unwitnessed." 3/7/07 6:00 a.m. "Res. states he had walked to B.R. with walker and walked back to chair and rolled on to the floor....Unwitnessed." 3/8/07 4:20 a.m. "Res. up in B.R. brushing teeth lost balance fell to floor.....unwitnessed." 3/9/07 1:00 a.m. "Res up amb. (ambulating) I (independently) to BR(bathroom) lost balance fell backwards to floor. AROM (active range of motion to all extremities. small laceration noted to L side of head by ear.....unwitnessed." 3/10/07 5:00 a.m. "Res. attempting to get up to go to BR and slid to floor no visible injuries noted AROM (active range of motion) to all extremities.....unwitnessed." 3/10/07 4:30 p.m., "Resident found on floor going to the bathroom. Able to move all extremities. Did not hit head. No new injuries noted." 3/10/07 9:30 p.m., "Resident attempted to get self up to bathroom-found lying on back with t.v. lying/resting on Rt. side neck. Able to move all extremities." (body diagram shows bruising to left neck area and abrasion to the right back, rib area). 4/26/07 10:00 p.m. "Resident found on floor next to bed on pad. Only injury was a 1 cm. (centimeter) X 1.5 cm. skin tear on R.(right) knee. Laying on back. Able to move all extremities. Neuros WNL (within normal limits). Environmental: mattress pad on floor. Body alarm on.....unwitnessed." 4/29/07 8:15 a.m. "Res was taken into BR and put on toilet. Call light handed to him. Turned light on and before aide got in there he was sitting on floor....more confused at times. Occurred in Dining room bathroom.....witnessed." 5/8/07 7:15 p.m. "Asking CNA (certified nurse aide) to help me with another resident when	F9999		

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F9999	Continued From page 46 finished with (R1). CNA left to go get him a gown and asked (R1) to wait for him. Before CNA could leave (R1) stood and fell hitting R (right) forehead on cabinet....red area to forehead R side....Bump R forehead....witnessed." 5/28/07 9:30 a.m. "Resident attempted to transfer self from w/c to bed and slid to floor landing on gluteus....No apparent injury....pressure alarm....unwitnessed." 6/3/07 11:00 a.m. "Res. was trying to walk from w/c to bed with walker when he lost his balance and fell to the floor, landing on his left side.....abrasion/bruise R side of face...pressure alarm.....unwitnessed." 6/10/07 12:25 p.m....."Dining room....res. sitting at table eating. (w/c locked when he was brought in) when he started to lean forward and w/c started to move backwards and he then fell forward and hit floor. Comments/Concerns....had been known to unlock wheel chair....he had a laceration on his forehead, and skin tears on the back of L hand. His breathing was labored, his eyes fixed and glazed over. Not responding to verbal stimuli.....Sent to local hospital." 6/12/07 8:30 p.m. "Resident tried to get up on his own without asking for help and fell on R side. No injury except reopened two scabs on R elbow. cleansed covered with (non adherent) dressing and roll gauze. Neuro's.....unwitnessed....no other interventions." A Fall Risk Assessment was attached to this Incident log with no date, but included a fall risk score of 22 (10 or above represents HIGH RISK) 7/16/07 1:30 a.m. "Resident attempted to walk to w/c falling on bedside mat. Res hit occipital portion of head on bed small laceration noted. B. (blood) sugar 198 @ time of fall. Neuro's....unwitnessed....interventions--(none)."	F9999		

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F9999	Continued From page 47 3. According to the July 2007 physician order sheet, R4 is a 105-year-old-female admitted 4/13/05 with diagnoses of Atrial Fibulation, and Gastric Esophogeal Reflux Disease. On 9/13/06 R4 had an Open Reduction Internal Fixation of the Right Hip due to a fall in the facility. The assessment dated 6/7/07 indicates that R4's cognition is moderately impaired with short term memory loss. R4 has a history of falls in the past 30 days and 31-180 days with hip fracture. R4 requires extensive assist with transfer, ambulation, and hygiene/bathing. The assessment - "Resident is at risk for further falls related to confusion due to diagnosis of senile dementia with poor safety awareness and unsafe decisions and not understanding her physical limitations. Personal alarm is used for safety. Will proceed with plan of care prevention." The Care Guide dated 6/12/07- Safety Notes: "I'm at risk for falls due to poor safety awareness, impaired cognition, behavior problems and a fall in the last 6 months resulting in hip fracture. There is a night light in my room and the staff leaves the bathroom door open for me. My goal is that I will be free from injury related to incidents for the next 3 months. The nurse will report all incidents to my doctor and family. They will record each incident and evaluate for a common cause that may prevent future incidents. Remind me that I am unable to get up per myself and that I need to call for assistance. Ensure the call light is within easy reach at all times that I am in my room. Be sure personal alarm is used at all times for added safety. My last fall was 5/2007."	F9999		

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F9999	Continued From page 48 The Incident Report dated 5/5/07 revealed that "R4 fell at 3:30 PM and was found sitting on the floor in the room in front of the wheelchair. R4 was vague as to what happened. Denies discomfort. No lacerations, contusions or abrasions noted." According to this document this is the 3rd fall in the past 31-180 days. The Recommendations/Intervention section is blank. The other Incident Report that was presented was dated 6/12/07 at 1:30 PM, "(R4) was found sitting on bottom- puddle of urine. Alerted by maintenance. The physician was notified on 6/14/07 while doing rounds in the facility. The Recommendations/Interventions section is blank. The care guide does not address the falls and provide new interventions to prevent future falls. There is no documentation to indicate that the falls are reviewed to analyze for trends and patterns. 4. The current physician's order sheet indicates that, R3 is a 75-year-old-female with diagnosis of Alzheimer's Dementia Gastro-Esophogeal Reflux Disease and Peripheral Vascular Disease. The assessment dated 4/23/07 indicates that R3's cognition is severely impaired. R3 needs extensive assist with transfers, dressing, hygiene/bathing and ambulation. The Care Guide dated 4/5/07 indicates that R3 is "unable to ambulate, I utilize the wheelchair for mobility propelled by others. I need extensive assist with transfers to and from the chair and bed." Safety Notes: "I'm at risk for falls due to weakness, poor decision making abilities. I do utilize a wheelchair for mobility so please monitor my position and correct as needed. My goal is that I will be free from incidents for the next 3 months."	F9999		

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F9999	Continued From page 49 The Incident Report dated 3/5/07 indicates that at 10:30 PM, "R3 was found lying on her side in the room on the floor pad. Resident appears like she rolled out of bed. Resident is confused, unable to say how she fell." The Recommendation/Interventions section is blank. The Care Guide does not address this fall or provide any interventions to prevent future falls. The incident report dated 5/31/07 indicates that a Certified Nurses Aide found R3 at 10:50 PM "sitting on knees on the mattress below her bed, her hands and head was resting on the bed." The Recommendation/Interventions section of the report is blank. The Care Guide does not address this fall. The Incident Report dated 6/9/07 indicates that "R3 was found kneeling on floor next to bed at 12:15 Am next to bed on floor pads. Old blister that had broken was dressed." The Recommendation/Intervention section of this report is blank. The Care Guide does not address this fall. The Incident Report dated 6/24/07 indicates that at 2:30 AM, "R3 was found on mattress on floor. No apparent injuries at this time. ROM is WNL (range of motion is within normal limits) for resident, denies pain/discomfort. Protocol for unwitnessed fall initiated, assisted to bed with 2 assist without difficulty." The Care Guide does not address the falls or implement any interventions to prevent further falls. There is no documentation to indicate that the falls are reviewed to analyze for trends or patterns to prevent further falls.	F9999		

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F9999	Continued From page 50 5. R8's July 2007 POS states that she has the diagnoses of Non-Insulin Dependent Diabetes Mellitus, Hypertension, Osteopenia, Parkinson's Disease, Polyradiculopathy, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Arthritis, Chronic Renal Failure, Dehydration and Urinary Tract Infections. The assessment dated 7/11/07 states that R8 "requires extensive assistance of 2 with stand lift with transfers and toileting, extensive assist of 1 for bed mobility, ADL's (Activities of daily living) ambulation with w/w (wheeled walker)....displays an unsteady gait, and poor safety awareness due to the aging process and diagnosis of dementia....recent hospitalization of volume depletion, UTI and acute kidney injury.....has had falls in past 30 days and 31-180 days and is at risk for further falls." The assessment dated 7/11/07 states that R8 needs extensive assistance of 2 persons for transfers, toileting and ambulation and extensive assistance of 1 person for bed mobility." R8's Care Guide dated 7/17/07 states that she "needs extensive assistance of two and gait belt for all transfers (nsg). The Care guide states that R8 has a "history of falls and that R8 has a body alarm when in the w/c (wheel chair) and a sensor pad when in bed." Facility Incident Reports list 2 falls for R8 between February 12th and April 15, 2007. "2/12/07 10:45 p.m., Res. was noted sitting on buttock in front of w/c on side of bed. PROM (passive range of motion) done with very little difficulty. Res up 2:1 assist to bed. No complaints of pain at this time....Under Recommendations/Interventions: remind to ask	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146099	A. BUILDING _____ B. WING _____	08/01/2007

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FRIENDSHIP MANOR	**1209 21ST AVENUE ROCK ISLAND, IL 61201**

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F9999	Continued From page 51 for help. To use call light.....number of falls in past 30 days: 2." "4/5/07 12:10 a.m. P/A (personal alarm) sounded. Found on floor in sitting position leaning back against bed. Verbally responsive. Assisted back into bed with 2 assist and gait belt....no recommendations or interventions." The Care Guide dated 7/17/07, does not list these falls nor provide any new interventions to prevent future falls. 6. The Physician Order Sheet dated 7/07 indicates that R17 is a 101-year-old-female with diagnoses of Congestive Heart Failure, Hypertension, Hypokalemia, Gastroesophageal Reflux Disease, Colitis, Hypokalemia, Coronary Insufficiency and Transient Ischemic Attacks. R17's assessment dated 5/15/07 indicates that R17's cognitive skills for daily decision-making is modified independence with some difficulty in new situations only. R17 transfers independently, ambulates independently with walker, dresses independently and maintains personal hygiene with supervision and set up help only. R17's Fall Risk Assessment dated 5/15/07 indicates that R17 is scored at high risk for falls. The incident report dated 4/27/07 at 8:30AM indicates that R17 fell in the dining room with her walker. "Stumbled and fell on buttocks. No apparent injury." The Fall investigation Worksheet states that R17 just lost her balance when her walker caught on someone else's chair. The Recommendation/ Intervention section is left blank. The incident report dated 6/6/07 at	F9999		

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F9999	Continued From page 52 9:00PM states that R17 was in her room trying to get up and slid to the floor on her bottom. No apparent injuries. The Fall Investigation Worksheet Recommendation/Interventions section is left blank. The care plan dated 5/17/07 under the Mobility section it states: "Ambulating: I'm up ab lib with the walker. Since I have had a recent room change please give me verbal cues in the right direction-I have a tendency to go back to my old room. I am able to transfer myself. I am able to reposition myself in the chair and bed. I do not use side rails. I use the wheeled walker while ambulating. Pt screens me quarterly for any possible needs" Under the Safety Notes section it states "I am at risk for falls related to age and increased confusion. My goal is to remain free from incident/injury for the next three months." The care plan does not address these falls or provide any interventions to prevent future falls. There is no documentation to indicate that the falls are reviewed to analyze for trends and patterns. (A) 300.615f) 330.715b) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual	F9999		

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F9999	Continued From page 53 is listed as a registered sex offender. Section 330.715 Request for Resident Criminal History Record Information The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. Theses Regualtions are not met, as evidenced by the following: Based on interview, the facility failed to check both Illinois sex offender registration sites upon admission of all residents admitted in approximately 13 of the last 13 months. Findings include: When E1 (Administrator) was interviewed on 7/24/07 at approximately 10:00 AM regarding how the facility documents the 2 sex offender website screens done on resident admissions, she stated that the facility has not been doing them. E1 then clarified that social service is responsible for that task, and that on 6/12/06, E12 was hired as the new social service designee. E1 said that criminal background checks for new admissions have been done, but that the 2 sex offender websites have not been checked for each new admission since E12 started. E1 said that apparently E12 was not informed with regards to that task she was responsible for when she started about 13 months ago.	F9999		

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F9999	Continued From page 54 (B)	F9999		