STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146033	A. BUILDING _____ B. WING _____	03/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMS, THE	**1212 MADELYN AVENUE MACOMB, IL 61455**

(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 520	Continued From page 39 meetings. E3 also stated that resident fall issues are not discussed in either of those 2 meetings, and that the weekly Fall Focus meeting is the facility's method for addressing resident falls. Interview with E5 (North Wing Care Plan Coordinator) on 3/15/07 at 11:15 AM indicated that she only attends the monthly QA meetings for department heads, and that resident fall issues are not part of that meeting. Review of the Resident Roster Matrix provided by the facility indicated that the assessments for 22 residents (of a total census of 95) triggered falls as a care issue.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210a) 300.1210b)6) 300.1220b)2)3) 300.3240a) 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	F9999		

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F9999	Continued From page 40 assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 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. 8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and	F9999		

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F9999	Continued From page 41 restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requitrements were not met as evidenced by the following: Based on observation, record reviews and interviews, the facility failed to evaluate the circumstances of falls, failed to assess the residents for 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 and minimize the risk for serious injury for 9 of 13 residents (R1, R4, R10, R11, R12, R16, R17, R18, R19) in the sample. These failures resulted in four of these residents (R11, R19, R1, and R18) sustaining fractures due to falls. The residents continued to be at risk for other serious harm, injury, or death. Findings include: The facility's undated policy "Accidents and Incidents-Investigating and Recording" states ...the charge nurse and/or the department director or supervisor must conduct an immediate investigation of the accident or incident...including...any corrective action taken; and follow-up information..." "Fall focus	F9999		

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F9999	Continued From page 42 committee meets weekly, generally on Wednesday afternoon after care plan conference. The resident Accident/Incident reports are reviewed for the previous week. Interventions are discussed and evaluated." During interview on 3-13-07 at 2:00 p.m., E2, Director of Nursing, E3, Assistant Director of Nursing and E10, Care Plan Coordinator, indicated each week all fall incidents are reviewed by a fall focus committee and recommendations made are listed on the fall focus sheet which is put in a book for staff review along with residents' care plans and Kardex. All the these forms are used by staff as fall interventions. Record review and observation confirmed that the facility failed to follow their own policies and procedures regarding investigation of falls, assessment of the circumstances, and the implementation of individualized approaches to prevent future falls. Multiple residents were noted to have multiple instances of unwitnessed falls with little to no investigation by facility staff into the circumstances regarding the falls. Interventions were not individualized nor based on in-depth analysis of the possible reason for continued falls. Facility did not consistently implement approaches and did not routinely make all staff aware of what approaches were to be implemented based on their limited investigation. E2, Director of Nursing, stated on 3/15/07 at 10 a.m. that the facility has two Quality Assurance Committees, one which is held monthly with Department Heads and one which meets quarterly and involves the Medical Director. E2	F9999		

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F9999	Continued From page 43 stated that resident fall trends and preventative actions are not discussed in either of these meetings. According to the Director of Nursing, the Medical Director is only provided with information regarding incidents which would be reported to the State Agency (this would therefore limit any analysis by the Medical Director of any pattern of increasing falls in the facility). During this same interview, E2 stated that results from the weekly Fall Focus Committee meetings are not addressed at either the monthly or quarterly Quality Assurance Committee meetings, again limiting any analysis of the root causes of the falls or analysis of the trends/patterns of falls in the facility. During interview with Z1(Medical Director) on 3/16/07 at 1:15 p.m, Z1 stated that resident fall issues are not covered in any detail with him at the Quality Assurance Committee Meetings, but he believed the facility staff would bring the issue to his attention if the facility was experiencing an upward trend in falls. Z1 acknowledged that he was not aware of any unusual trend in resident falls at this time. 1) R11's admission face sheet dated 7/17/06, indicates that R11 is 96 years of age with Diagnoses including: Dementia, Status Post Left Hip Fracture, Back Pain and Depression. The resident assessment for R11 dated 8/16/06 indicates that R11 is severely impaired in cognition, is totally dependent for all activities of daily living and is non ambulatory. The Resident Assessment triggers falls and is marked to be care planned. R11's medical record includes in the admission records, a hospital History and Physical dated	F9999		

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F9999	Continued From page 44 7/4/99 that reports that (R11) was living with her daughter and had fallen at the daughter's home a week prior. "Assessment: Fall one week prior to admission to hospital. Suspected occult compression fracture." A hospital History and Physical dated 12/18/00 documents that (R11) was admitted to the hospital after falling at this nursing home with a left hip fracture. The 5/28/03 History and Physical states, "(R11) resident of the nursing home, who over the last several days has had multiple falls. This is not the first time, R11 had falls in the past. (R11) fell last Friday, had an x-ray of the pelvis without evidence of fracture. R11 apparently had another fall on the day of admission, striking her head. Hospital Consultation Note dated 5/30/03 reports (R11) nursing home resident had fallen several times in the last few days. (R11) must have injured her knee during one of those falls. An x-ray was obtained today which demonstrates a right patella (knee) fracture." R11's care plan dated 5/25/06 was reviewed. Fractured neck and fall of August 6 are noted on the care plan at problem #10 which refers to dependent for ADLS (activities of daily living) with a goal to insert arms in sleeves but lists no interventions to prevent falls. The only other place in the care plan where falls are mentioned is problem #11, referring to transfers with a goal of rolling side to side with hands on assist and so on related to transfers. There are no interventions for fall prevention found anywhere in the care plan. On 3/24/07 at 11:00 a.m., E10, RN (Registered	F9999		

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F9999	Continued From page 45 Nurse) for care plans was interviewed regarding where falls are addressed on the care plan. E10 was shown the care plan, E10 stated, "I don't see anything. I think the care card at the nurse station does have personal alarm on bed and chair and low bed." No revisions were noted on the card upon review. R11 was in a wheelchair in the dining room on 3/14/07 at 11:45 a.m. E9, CNA was feeding R11 and E11, RN was feeding another resident behind them. R11's wheelchair was observed to not have a personal alarm on it nor did the resident. E9 was asked if there was supposed to be a personal alarm. E9 stated, "I'll have to ask." E9 then turned to E11, RN, who stated, "Yes she is." E9 then retrieved and attached a personal alarm to R11 and to the wheelchair. R11's nursing notes for 8/13/06 at 9:30 a.m. state, "R11 was found lying prone with head turned to right side and left arm twisted behind her. Blood on floor around head, 2 small lacerations on forehead, complained of neck pain." Nursing note (back note) for 9:30 a.m. states (Personal Alarm) was put on R11 just prior to fall. R11 may have taken it off of herself. R11 was sent to Emergency room. A History and Physical dated 8/13/06 regarding R11 indicates that R11 fell from wheelchair that day. R11 received a laceration on her forehead as well as an Odontoid fracture (fracture of C2, the 2nd Cervical space of the spine). Facility incident report dated 11/11/06 at 4:45 p.m. states, "R11 heard yelling. Found lying on right side facing bed with head at food of bed. 2 centimeter scrape on knee. Clip to personal	F9999		

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F9999	Continued From page 46 alarm defective. Safety pin used to replace defective clip." 2) The current admission face sheet for R19 indicated that R19 was admitted to the facility on 11/22/05, was 89 years of age with Diagnoses including: History of Falls, Anxiety, Depression, Back Pain, and Lumbar Radiculopathy. Fall Risk was reviewed. R11 scored a 17 with 10 being high risk. A History and Physical dated 10/17/05, just prior to R19's admission to the nursing facility, notes R19 presented to the hospital with back pain which began about a week after a fall at home. Facility incident report dated 5/20/06 at 4:00 p.m. for R19, reports, "Staff heard a resident yelling for help. Found (R19) sitting on the floor in her room. States, R19 dropped her water, tried to get it and fell. Personal Alarm had been in place, R19 apparently took it off. (Alarm) did not sound to alert staff. Complained of head hurting. Small bruise to right temporal area. Orders to transfer to emergency room for evaluation." 5/20/06 investigation reports resident confused with unsteady gait and that the floor was wet. A 5/23/06 hospital History and Physical documents that R19 was admitted this day, 5/20/06, for a Fall, Pelvic Fracture and a Concussion. It states that R19 had had progressive falls at the nursing home. Incident report dated 5/23/06 at 9:20 a.m., R19 found on knees beside bed. Investigation states socks on, no shoes, and removed personal alarm per self. Recommendations is blank.	F9999		

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F9999	Continued From page 47 On 3/5/07 at 12:05 am, facility incident report for R19 notes; "Staff heard resident yell 'Help.' R19 was found sitting on buttocks by side of low bed. Bed alarm was attached to (R19) including the bed part so the whole alarm was hanging from R19." The investigation dated 3/5/07 is blank under Recommendations. On 3/14/07 at 11:55 am, R19 was in a wheelchair in the dining room. A clipped string was noted attached to R19's clothing. The actual personal alarm, with string still attached was lying in the seat of her wheelchair and not connected to the chair. E9, CNA was feeding in the dining room and was asked to look at the alarm on R19. E9 stated, "The alarm is here, but not hooked to the chair." E9 picked up the personal alarm and attempted to attach it to the wheelchair per the interlocking attachable fiber strip on the back of the chair. E9 stated, "It won't stick. I'll get new a new piece." The attaching strip was observed to be well worn and appeared to have been there for a long time. The care plan for R19 dated 1/17/07 did not include any new interventions to prevent further falls. 3) The current admission face sheet for R1 indicates that R1 is 80 years of age. R1's Diagnoses include: Paralysis Agitans, Senile Dementia, Altered Mental Status and Parkinson. R1's Resident Assessment dated 9/13/06, indicates that R1 required supervision for transfers and ambulation, required partial physical support for balance, and has fallen the past 31 to 180 days. R1 was moderately impaired for cognitive skills for daily decision making and had long and short term memory problems. The	F9999		

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F9999	Continued From page 48 Fall Resident Assessment dated 9/21/06 was reviewed. It states, "R1 has a history of falls. R1 has gone from independent to now ambulating with assistance of 1." Fall Risk Assessment for R1 indicates R1 is high risk for falls, scoring an 18 with 10 or above being high risk." The facility incident report for R1 dated 10/26/06 at 7:00 p.m., notes R1 to have stood up alone and fell to the floor in her room. Investigation on the same day reports R1 had socks on and no shoes. It notes resident to be confused. Investigation recommendations to prevent further falls is left blank. R1's incident report dated 11/3/06, indicates, "Staff heard a trash can bang and noted R1 laying on the bathroom floor. No witness. Apparently lost balance while going into the bathroom." Investigation recommendations to prevent future problems was left blank. Incident report dated 11/05/06 at 6:30 p.m., reports, "Heard someone yelling down the hall found R1 sitting on the floor. States R1 slipped off the bed." Investigation report or same day indicates resident is confused,disoriented and is unsteady at times. No apparent injury. Recommendations area is left blank. On 11/18/06 at 3:45 a.m., it is documented on the incident report that staff entered room and noted R1's feet sticking out of the bathroom. R1 was noted on the floor lying on her back. Noted a 1 cm (centimeter) by 1 cm bruise on her right upper arm. Investigation report notes, "Need personal alarms but daughter refuses." Also notes socks on but no shoes, unsteady gait, and decreased cognitive status.	F9999		

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F9999	Continued From page 49 Incident report for R1 dated 12/11/06 at 11:55 pm indicates that R1 was found sitting on the floor of another resident's room. Investigation of the fall dated 12/11/06 notes R1 had socks on and no shoes, had an unsteady gait and the room was dark. Two days later on 12/13/06 at 7:10 am, an incident report states, "R1 would not stand and was lowered to the floor. R1 complained of right hip and buttock pain. Assisted to wheelchair, transferring poorly. At 11:20 am R1 laid down in Physical Therapy. Right leg approximately one inch shorter than left leg and externally rotated. Right thigh is swollen. Sent to ER (Emergency Room)." History and Physical dated 12/13/06 documents, "(R1) fell on Monday, 2 days prior. At that time R1 was able to bear weight and was not complaining of considerable pain. The day of presentation R1 began to refuse to bear any weight on the right leg which is noted to be shortened and rotated. R1 was brought to ER where x-rays confirmed the presence of a subcapital hip fracture which had become displaced." R1's care plans were reviewed for 9/21/06 and do not note falls on the problem list. R1's Resident Assessment Narrative Report dated 9/21/06 indicates that R1 triggered for falls on the Resident Assessment and states, "We will add approaches on the care plan." There were no approaches found on the care plan of 9/21/06. The 1/11/07 care plan was also reviewed and also failed to provide any interventions to prevent falls. 4) The admission face sheet for R17 indicates	F9999		

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F9999	Continued From page 50 that R17 is 80 years old and has Diagnoses including: Dementia without Behavioral Disturbances, Alzheimer's Disease and Hypertension. The Resident Assessment dated 2/21/07 documents R17 to have both long and short memory problems, to be moderately impaired in cognition and is only alert to staff names /faces and that she is in a nursing home. This Resident Assessment notes that R17 is totally dependent for transfers, requires extensive assist for locomotion and is nonambulatory. Facility incident reports for R17 dating from 5/4/06 to 3/13/07 total 47 in number. Some of the incidents included in the 47 incident reports are as follows: 5/4/06 at 7:20 a.m., R17 found lying on foot pedals of wheelchair. 2 cm by 2 cm (centimeter) skin tear to left arm. 5/9/06 9:15 a.m., R17 on floor, string on personal alarm had broken, alarm did not sound. 5/28/06, 1:40 a.m., "R17 observed lying on floor, had removed personal body alarm and slid out between the headboard and side rail. 1.5 cm by .25 cm abrasion to upper coccyx." 5/30/36 11:55 p.m., Alarm sounding found R17 kneeling on floor, 10 minutes later at 12:05 a.m. on 5/31/07, second fall personal alarm came off bed and was hanging from her gown. 6/25/06 12:45 a.m., found R17 lying on floor. Call light cord had ben pulled out of the wall. Resident had removed personal alarm. Large bruises and 2 skin tears found on right elbow. Resident had attempted to get out of bed 30 minutes prior.	F9999		

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F9999	Continued From page 51 7/9/06 6:15 a.m., Staff responded to R17's husband yelling for help. Found R17 lying on left side with wheelchair tipped over on top of her. 7/11/06 4:10 p.m., E2, Director of Nursing found resident in dining room on her back with her head under the wheel chair between the wheels. One end of lap cushion was loose. 7/22/06 8:10 p.m., CNA looked into room, hearing R17 talking. Wheelchair and bed were empty. Found R17 on the floor on her back in front of her closet with the closet door open and her head inside the closet. Investigation, same date, Confused, disoriented, unsteady gait, torso support in place. Resident's increased mobility and confusion contributed to her fall. 8/4/06 5:35 a.m., Dietary staff summoned for R17 lying in the doorway with door held open by R17's legs. 8/14/06 12:15 a.m., Staff found resident lying partially on floor next to bed. Investigation notes: Personal alarm was on but not sounding. 8/17/06 3:20 a.m., Responded to personal alarm, found R17 partially on floor and partially in bed. Roll bolster had rolled off bed and was under resident. Investigation: roll bolsters loose and rolled off with her. Did not prevent fall. 8/18/06 4:50 p.m., Found lying on back with head underneath the wheelchair. 8/27/06 10:30 a.m., (Visitor) summoned staff, 'Someone on the floor in the lobby.' R17 lying on right side in front of wheelchair. 2 cm by 1 cm	F9999		

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F9999	Continued From page 52 abrasion noted to lateral aspect right knee. R17 was wearing torso support. 9/5/06 12:25 p.m., R17 eating in dining room. Heard staff gasp and saw R17 fall out of wheelchair, hitting head on wheelchair then landed on her back on the floor. 9/9/06 6:40 p.m. and 6:50 p.m., resident slid down out of wheelchair two times within 10 minutes. 2 cm skin tear on left elbow. On floor again at 10:15 p.m. with no apparent injury. 9/10/06 a.m., Nurse passing medication noted R17's lower half of body hanging down from wheelchair. Called for help and no one near to hear had to lower to the floor and go for help. 10/7/06 7:00 p.m. and 9:10 p.m., Called to the other hall nurse station and informed that R17 on the floor in front of her wheelchair. Found again on floor at 9:10 p.m. in R17's room on floor beside bed, with a 0.5 cm abrasion to right knee. Personal alarm still pinned to resident, but did not sound. 10/21/06 4:10 a.m., CNA found R17 on floor by bed. Had apparently removed personal alarm string from gown. 10/23/06 4:00 p.m. found on floor. Had removed personal alarm. 11/19/06 7:15 a.m., Nurse saw R17 lean forward and fall on to the floor from wheelchair, hitting the right side of her head on the floor. Has a 1 cm lump above right eyebrow and a 1 cm bruise to rise side of R17's nose.	F9999		

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F9999	Continued From page 53 12/2/06 12:30 p.m., Found R17 sitting on floor beside bed. Personal alarm still hooked on shirt. 2/20/07 11:15 a.m., CNA noted R17 slid out of wheel chair and lying on floor at end of hall. Complain of back and head hurting. Noted quarter sized reddened area back of head (occipital region) and Thoracic spine area slightly reddened. Investigation, same date, "Postural supports do not work for her. Took it off. Resident states she's going to keep sliding down until she gets a different chair." 3/5/07 12:58 p.m., R17 in front of housekeeping office with personal alarm going off. Head against doorway. 3/5/07 5:15 p.m., CNA entered dining room and found R17 sitting on the floor in font of wheelchair. R17's care plan dated, 9/14/06, 12/7/06 and 3/1/07 were reviewed and compared for falls. The interventions were identical on all three dates. There were no new or effective interventions noted on the care plans. 5) R4's current face sheet notes R4 was admitted to the facility on 8/22/06. R4 is 77 years of age with Diagnoses including: Organic Brain Syndrome, Dementia, Cerebral Degeneration and History of Falls. The Resident Assessment for R4, dated 1/3/07, notes R4 to be severely impaired in cognition and dependent on staff for all activities of daily living. Fall Risk dated 10/4/06 scored R4 at 19 based on 10 and above as high risk. The Resident Assessment triggers falls. The Resident Assessment dated 1/4/07 shows falls triggered and to proceed. It states that R4 has a	F9999		

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F9999	Continued From page 54 history of falls, unable to transfer self and ambulate, and has poor sitting balance. A hospital History and Physical dated 7/27/06, just prior to the nursing home admission on 8/22/06 notes that R4 was admitted to the hospital at that time due to falls. It reports that R4 was found by neighbors after she had fallen in the yard a couple of houses down from her normal home. The facility incidents reports for R4 from 9/19/06 to 12/16/06 document a total of 19 incident reports during this 3 month period. The reports indicated that R4 was found on the floor either by her bed or wheel chair on: 9/19/06, 9/24/06, 9/29/06, 10/12/06, 10/17/06, 11/13/06, 11/15/06, 11/17/06, 11/20/06, 11/14/06 and 12/3/06. On both 10/1/06 and 10/9/06, R4 was reported to have taken off her wheelchair lap cushion and fallen. R4 was found face down in the unlocked shower room on 10/19/06. On 10/16/06, R4 stood up from the bathroom, dribbled, slip on the wet floor and fell. R4 fell on 10/18/06 after removing a wheel chair belt. R4 was found on the dining room floor on 11/9/06 without her personal alarm as a safety pin had to be attached to the string which had a defective clip. The 12/16/06 report indicates that R4 bumped her head on the toilet with staff present. Care Plan for R4, dated 1/11/07, does mention history of falls in the medical history. It give a short term goal to remain safe in her environment and maintain optimal comfort. There are no approaches for preventing falls. The interventions are to be aware resident is nonverbal, keeps eyes closed and is dependent on staff for all	F9999		

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F9999	Continued From page 55 ADLs. Speak in comforting voice, monitor skin and facial grimacing or restlessness indicating discomfort. Provide oral care and monitor overall physical status such as vital signs, cardiac and respiratory status and signs of Urinary Tract Infection. The care plan has no mention of personal alarm, wheelchair lap cushion, or wheel chair belt as at times were mentioned on the incident reports as being ineffective or not in place. 6. R12's current physician's order sheet for March 2007 indicates R12 is 77 years old with diagnoses including Alzheimer's disease with agitation and combativeness, Parkinson's disease, hypertension, osteoarthritis, and trans ischemic attacks. R12's fall risk assessment dated 1-8-07 shows R12 to be a high risk for falls. R12's care plan dated 1-31-07 states R12 is at risks for falls and lists the following interventions; place lap cushion to aid with positioning related to poor safety awareness and fall history, connect personal alarm when up in the wheelchair and bed, offer toileting or rest period when wandering in wheelchair. R12's fall focus sheets indicates R12 has fallen four times this year. Fall #1 - On 1-28-07, the Resident Occurrence and Investigation report states R12 was found sitting on floor on his buttocks next to his wheelchair and bed, had taken off postural support. The investigation section states "resident very confused and hard of hearing, unable to state what he was doing." The section "recommendations to prevent future problems" is blank. The fall focus intervention states to evaluate for a lap cushion or reclining wheelchair.	F9999		

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F9999	Continued From page 56 Fall #2 - On 1-31-07, the Resident Occurrence and Investigation reports states R12 was observed to stand up by hallway bathroom and tried to walk but tripped over foot pedals of the wheelchair landing on his right side. The investigation section states "very confused and attempts to get up on own without assistance. "Does resident use postural supports?" is marked "yes" but "resident had taken off - removes numerous times." The section "recommendations to prevent future problems" is blank. The fall focus intervention states to evaluate for use of lap cushion and therapy evaluation. Record shows R12 was discharged from therapy that same day. Fall #3 - On 2-7-07, the Resident Occurrence Report states R12 was found in room by wheelchair. R12 had removed his personal alarm and postural supports. No recommendations were made on the investigation report. The fall focus sheet states to now use a lap cushion and ambulate R12 to the dining room. Fall #4 - On 2-19-07, the Resident Occurrence Report states R12 was "found sitting on floor in the visitors bathroom up against the wall. Had removed his bumper pad and apparently tried to take self to bathroom, was incontinent of urine." The investigation section states resident "attempted to take self to bathroom." The section for recommendations is blank. The fall focus intervention states to increase ambulation and toileting. On 3-14-07 at 11:00 a.m., R12 was observed sitting in a dining room chair without a personal alarm on. At 12:00 p.m., E6, Registered Charge	F9999		

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F9999	Continued From page 57 Nurse attached a personal alarm to R12 and his chair. At 1:55 p.m., R12 was observed up in a hi-back wheelchair in the hallway with a lap cushion on. R12 did not have a personal alarm on. E4, Registered Nurse in charge of the rehabilitation department confirmed R12 should have been had a personal alarm on as per his care plan. 7. R10's current physician's order sheet for March 2007 indicates R10 is a 93 year old with diagnoses including senile dementia, fatigue and anemia. R10's fall assessment dated 1-30-07 shows R10 to be at high risk for falls. R10's care plan dated 2-2-07 states R10 is at high risk for falls and lists the following interventions; roll bolsters on bed as tactile barrier, place call bell in reach, repositioning and toileting program. During interview on 3-13-07 at 2:00 p.m., E2, Director of Nursing, E3, Assistant Director of Nursing and E10, Care Plan Coordinator indicated each week all fall incidents are reviewed by a fall focus committee and recommendations made are listed on the fall focus sheet which is put in a book for staff review along with resident's care plans and Kardex. All the these forms are used by staff as fall interventions. R10's record shows R10 fell 10-29-06, 12-27-06, 1-19-07 and 2-17-07. After the 12-17-06 fall, the fall focus sheet gives an intervention to prevent further falls. This intervention states "recommendation: staff will be reminded to place safety pin (personal alarm) to middle back of her clothing..." R10's incident report for the 1-19-07 fall states R10 was found on the floor in her room..."(personal alarm) was off the head of the bed, unhooked from gown and found in middle of bed. Resident removes (personal alarm)	F9999		

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F9999	Continued From page 58 frequently." This investigation does not indicate whether R10's personal alarm was pinned to R10's clothing or not. On 3-12-07 at 11:55 a.m., R10 was up in a chair at the dining room table without her personal alarm on. At 1:15 p.m. and on 3-14-07 at 10:30 a.m., R10 was up in a wheelchair with her personal alarm on but no safety pin used to secure it to her clothing. This was confirmed by E12, Certified Nursing Assistant who stated "it just hooks on the back." At 11:35 the same day, R10's personal alarm was noted to be secured with a safety pin. 8. R16's current physician's order sheet for March 2007 indicates R16 is a 92 year old admitted 3-5-07 with diagnoses including history of a recent hip fracture with repair, pneumonia, psychosis and hypothyroidism. R16's fall risk assessment dated 3-5-07 states R16 is at high risk for falls. R16's care plan dated 3-14-07 states R16 has a history of falls and initiated the following as one of the interventions to prevent further falls; (personal alarm) in bed and wheelchair. On 3-15-07 at 10:30 a.m., R16 was observed in bed with no personal alarm on. This was verified by E8, Registered Charge Nurse. R16 was observed again at 10:45 a.m. and 11:00 a.m. without the alarm on. During interview on 3-15-07 at 12:55 p.m., E3, Assistant Director of Nursing confirmed that R16 did not have her personal alarm on that morning and verified that R16's care plan did call for the personal alarm to be on.	F9999		

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F9999	Continued From page 59 9. R18's current physician's order sheet for March 2007 indicates R18 has diagnoses including Alzheimer's disease, diabetes, hypertension, degenerative joint disease and history of hip fracture. R18's fall risk assessment completed 2-7-07 shows R18 to be at high risk for falls. Nursing notes dated 2-20-07 state "found resident halfway out of wheelchair on floor in resident room yelling 'help me'...'my leg hurts' right leg 2" shorter than left leg." R18 was admitted to a local hospital with a fractured right femur. R18's fall focus sheet for the incident on 2-20-07 explains how the incident happened but does not contain any interventions to prevent further falls. An order was obtained 3-1-07 stating "(personal alarm) on bed and wheelchair, check every shift" This intervention is not listed on R18's care plan dated 2-8-07, nor on any fall focus sheets or Kardex used by staff to find and use the fall interventions. On 3-14-07 at 11:40 a.m. and 1:40 p.m., R18 was observed in bed without her personal alarm on. E8, Registered Charge Nurse verified at 1:40 p.m. that R18 did not have her alarm on. During interview on 3-15-07 at 12:55 p.m., E2, DON, verified R18's has an order for a personal alarm in bed and wheelchair which is not included on the care plan. (A)	F9999		