STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	09/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH WICHITA, KS 67206

(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of complaint survey #102227 and #104529 at the above named facility on 9-7-16, 9-12-16, 9-14-16, and 9-15-16.	S 000		
S3028 SS=E	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by:	S3028		

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

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S3028	Continued From page 1 KAR 26-41-101(f)(3)(A)(B)(C)(D)(E)(F) The facility identified a census of 31 residents. The sample included 3 residents. Based on record review, interview and observation or 2 (#2) and (#3) of 3 residents sampled, the operator failed to ensure that all investigations shall be started when the administrator or operator, or the designee, receives notification of an alleged violation, immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress, each alleged violation shall be thoroughly investigated within five working days of the initial report, results of the investigation shall be reported to the operator; appropriate corrective action shall be taken if the alleged violation is verified, the department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report, and a written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. Findings included: - Record review for resident #2 revealed an admit date of 3-13-14 with diagnoses of brain injury from encephalitis. The FCS dated 11-5-15 recorded resident required physical assistance with bathing, dressing, transfer, toileting, bladder incontinence, communication, walking/mobility, experienced short-term memory loss, impaired memory recall, long term memory loss, impaired decision making, and falls/unsteadiness. The NSA/HCS dated 11-2-15 recorded staff to provide physical assistance with dressing and	S3028		

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S3028	Continued From page 2	S3028		

grooming, resident is unsteady on feet at times because he/she moves too quickly, required one person assist with grooming and dressing tasks pulling pants up and down. Resident required one person assist with showering, toileting, changing protective undergarments, toilet resident every two to four hours during the day and as needed at night. Resident uses restroom often, usually related to anxiety. Resident required assist of one with transfers, uses walker for mobility, . . .and needs to be escorted while ambulating. Resident is very impulsive at times and restless at night due to brain injury. Resident demonstrates anxious disruptive or obsessive behaviors requiring additional attention. When resident demonstrates anxious behavior, staff are to take extra time with resident and involve resident in activities. Word search is a good distraction for anxiety.

8-10-16 at 1:20 p.m. faxed order noted to use gait belt with transfers and ambulation.

6-10-16 at 4:25 a.m. "Notified by Certified Medication Aide (CMA) that resident had a witnessed fall. CMA was doing 4:00 a.m. rounds when he/she found resident on toilet. Resident went to stand up, lost balance falling backwards. Upon entry to room resident was sitting on bottom with feet in front of him/her. Resident stated hit back of head on wall. No open areas or complaint of headache/pain. "

The record lacked completed investigation to rule out abuse/neglect and report to administrator within 24 hours; immediate measure shall be taken to prevent further potential abuse/neglect while investigation in progress; thoroughly investigated within five working days of initial report; appropriated action shall be taken; the

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S3028	Continued From page 3 department's complaint investigation report shall be completed and submitted to the department within five working days of the initial report; and a written record shall be maintained of each investigation of reported abuse/neglect. 6-17-16 at 2:45 a.m. CMA notified this nurse resident was on floor in room. Upon entry to room resident was seen on bathroom floor with legs out in front of him/her. Another resident had wandered into resident's room and took his/her walker. Resident was very anxious and other resident was led out of room by staff. Upon assessment no injuries are observed. Resident does complain of pain to right buttock. The record lacked completed investigation to rule out abuse/neglect and report to administrator within 24 hours; immediate measure shall be taken to prevent further potential abuse/neglect while investigation in progress; thoroughly investigated within five working days of initial report; appropriated action shall be taken; the department's complaint investigation report shall be completed and submitted to the department within five working days of the initial report; and a written record shall be maintained of each investigation of reported abuse/neglect. 7-18-16 at 1:20 a.m. Resident had an unwitnessed fall. Resident was found sitting on floor by bathroom. Resident denied any pain at this time. Will continue to monitor. The record lacked completed investigation to rule out abuse/neglect and report to administrator within 24 hours; immediate measure shall be taken to prevent further potential abuse/neglect	S3028		

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S3028	Continued From page 4 while investigation in progress; thoroughly investigated within five working days of initial report; appropriated action shall be taken; the department's complaint investigation report shall be completed and submitted to the department within five working days of the initial report; and a written record shall be maintained of each investigation of reported abuse/neglect. 7-22-16 at 8:06 p.m. This nurse was notified by phone of resident having an unwitnessed fall around 6:30 p.m. Upon assessment resident was ambulating with four wheeled walker independently. No injuries present. The record lacked completed investigation to rule out abuse/neglect and report to administrator within 24 hours; immediate measure shall be taken to prevent further potential abuse/neglect while investigation in progress; thoroughly investigated within five working days of initial report; appropriated action shall be taken; the department's complaint investigation report shall be completed and submitted to the department within five working days of the initial report; and a written record shall be maintained of each investigation of reported abuse/neglect. 7-23-16 at 1:00 p.m. Resident arrived back from the hospital at approximately 9:30 a.m. by Emergency Medical Services (EMS). Resident presents with a hematoma on the back of head approximately 3 Centimeters (CM) by 3 CM in a circular shape. Resident ' s hematoma purple in the middle with redness surrounding. Resident denied pain. Resident ambulated with four wheeled walker and is on fall follow up. Family notified. (Record lacked documentation of the fall on 7-23-16.)	S3028		

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S3028	Continued From page 5 The record lacked completed investigation to rule out abuse/neglect and report to administrator within 24 hours; immediate measure shall be taken to prevent further potential abuse/neglect while investigation in progress; thoroughly investigated within five working days of initial report; appropriated action shall be taken; the department's complaint investigation report shall be completed and submitted to the department within five working days of the initial report; and a written record shall be maintained of each investigation of reported abuse/neglect. 7-27-16 at 4:00 a.m. late entry for 7-26-16 at 2:15 a.m. was notified by certified staff working by phone. Resident was found on floor in bathroom. Resident ' s brief was wet and was sitting on bottom with feet out in front of him/her with back against wall next to toilet. Instructed certified staff to assist resident up with use of gait belt. Resident did not use walker when ambulating to restroom. Resident was reminded to use walker. The record lacked completed investigation to rule out abuse/neglect and report to administrator within 24 hours; immediate measure shall be taken to prevent further potential abuse/neglect while investigation in progress; thoroughly investigated within five working days of initial report; appropriated action shall be taken; the department's complaint investigation report shall be completed and submitted to the department within five working days of the initial report; and a written record shall be maintained of each investigation of reported abuse/neglect.	S3028		

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8-21-16 at 10:20 p.m. Resident had an unwitnessed fall. This nurse was notified by certified staff that he/she came upon resident sitting on bottom on the floor at bedside. Resident stated, " fell on bottom " . Resident rubbing right leg, area assessed and put back in bed.

The record lacked completed investigation to rule out abuse/neglect and report to administrator within 24 hours; immediate measure shall be taken to prevent further potential abuse/neglect while investigation in progress; thoroughly investigated within five working days of initial report; appropriated action shall be taken; the department's complaint investigation report shall be completed and submitted to the department within five working days of the initial report; and a written record shall be maintained of each investigation of reported abuse/neglect.

On 9-7-16 at 4:00 p.m. observed resident in activity room sitting in chair with walker in front of him/her. Resident stood up and took few steps with walker then returned back to chair. No use of gait belt observed. At 4:30 p.m. observed certified staff C ambulate resident to dining room from activity room using walker. No gait belt used.

Confidential interview on 9-12-16 stated resident #2 had several falls recently and concerned about what facility staff are doing to help prevent falls. Resident is found on the floor in room and has a roommate. Door is locked from outside while both residents in room alone. Most falls happen during the evening/night time. Resident #2 is not

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S3028	Continued From page 7 able to use a call light or remember to use walker. Interview on 9-12-16 at 12:45 with licensed staff A stated and provided internal investigations of some of the falls for resident #2. Resident has a roommate and when residents in room the door is locked from the outside. Residents can open the door from the inside. Licensed staff A confirmed resident experienced short-term memory loss, memory recall, impaired decision making, and experienced agitation/anxiety and that incidents were not reported to the department and investigated. - Record review for resident #3 revealed an admit date of 3-4-16 with diagnoses dementia and macular degeneration. The FCS dated 3-4-16 recorded resident independent with toileting, transfer, communication, required physical assistance with dressing, bathing, incontinent of bladder, experienced short term memory loss, memory recall long term memory loss, impaired decision making and falls/unsteadiness. The NSA dated 3-4-16 recorded staff will assist with dressing, bathing, resident occasionally incontinent of bladder and able to provide self-care for incontinence. Resident independent with ambulation with a walker and verbal direction. Resident has impaired short term memory, memory recall, long term memory loss and decision making. Staff will assist with daily. Memory impairment is reason for escort service.	S3028		

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Resident log notes recorded the following:

6-30-16 at 4:15 a.m. At 4:00 a.m. a call light sounded and certified staff went to answer and requested assistance. Certified staff reported resident was on floor with walker. Resident found on floor in bedroom. Legs are bent and resident stated he/she is going to the bathroom. Resident #3 ' s roommate (resident #2) was on toilet and walker was in bathroom with resident #2. Resident #3 was checked for injuries and none noted. Resident does complain of left thigh pain. Resident able to move all extremities within normal limits. Vital signs blood pressure (B/P) 151/84, pulse (P) 69, respirations (R) 15, and temperature (T) 97.4. Physician faxed and requested an x-ray.

The record lacked completed investigation to rule out abuse/neglect and report to administrator within 24 hours; immediate measure shall be taken to prevent further potential abuse/neglect while investigation in progress; thoroughly investigated within five working days of initial report; appropriated action shall be taken; the department's complaint investigation report shall be completed and submitted to the department within five working days of the initial report; and a written record shall be maintained of each investigation of reported abuse/neglect.

7-6-16 at 1:00 a.m. Resident had an unwitnessed fall. This nurse heard resident moaning while assisting another resident went to check on resident and found resident with torso on bed and knees on floor. Resident was attempting to get up by self. Resident has a bruise underneath right eye, quarter sized purple bruise to left lateral hip and skin abrasions to right knee. Resident able to perform range of motion

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with normal limits. Resident complained of pain to left shoulder. New order for physical therapy consult. This is second fall in 2 days.

The record lacked completed investigation to rule out abuse/neglect and report to administrator within 24 hours; immediate measure shall be taken to prevent further potential abuse/neglect while investigation in progress; thoroughly investigated within five working days of initial report; appropriated action shall be taken; the department's complaint investigation report shall be completed and submitted to the department within five working days of the initial report; and a written record shall be maintained of each investigation of reported abuse/neglect.

8-2-16 at 7:49 p.m. Resident had an unwitnessed fall in the dining room at 12:15 p.m. Resident was found lying on left side. When turning resident on back he/she complained of pain in left hip and lower back. 911 was called. While at hospital lab showed resident had a urinary tract infection (UTI). At 3:45 p.m. resident returned to facility with diagnoses of UTI.

The record lacked completed investigation to rule out abuse/neglect and report to administrator within 24 hours; immediate measure shall be taken to prevent further potential abuse/neglect while investigation in progress; thoroughly investigated within five working days of initial report; appropriated action shall be taken; the department's complaint investigation report shall be completed and submitted to the department within five working days of the initial report; and a written record shall be maintained of each investigation of reported abuse/neglect.

8-22-16 at 9:15 a.m. Staff heard resident yelling

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S3028	Continued From page 10 and alerted this nurse that resident was on floor. Resident was flat on back with head facing door. Resident denied hitting head and complained of pain with ROM to left hip; leg; back; and left elbow. No lacerations or hematoma ' s noted. EMS notified due to left hip; leg; and back pain. The record lacked completed investigation to rule out abuse/neglect and report to administrator within 24 hours; immediate measure shall be taken to prevent further potential abuse/neglect while investigation in progress; thoroughly investigated within five working days of initial report; appropriated action shall be taken; the department's complaint investigation report shall be completed and submitted to the department within five working days of the initial report; and a written record shall be maintained of each investigation of reported abuse/neglect. 9-4-16 at 7:00 a.m. It was reported to this nurse that resident stated he/she had fallen during the night. Staff reported that at 3:00 a.m. they did rounds to toilet resident and resident was up in recliner in room and stated he/she had fallen while getting out of bed. ROM normal. Resident has a golf ball size bruising to left temple. Physician and family notified. Awaiting response. The record lacked completed investigation to rule out abuse/neglect and report to administrator within 24 hours; immediate measure shall be taken to prevent further potential abuse/neglect while investigation in progress; thoroughly investigated within five working days of initial report; appropriated action shall be taken; the department's complaint investigation report shall be completed and submitted to the department within five working days of the initial report; and a written record shall be maintained of each	S3028		

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S3028	Continued From page 11 investigation of reported abuse/neglect. Observation on 9-7-16 at 4:05 p.m. of resident #3 noted propelling self in wheel chair. Observed a dark bruise to right temporal area of head. Resident rubbed area and stated it hurt. Resident further stated he/she did not know what happened. 9-12-16 at 12:30 p.m. observed resident with dark blue bruise to right temporal area the size of a tennis ball. Resident in wheel chair propelling self around dining area. Interview on 9-12-16 at 12:40 p.m. with certified staff C stated the bruise is from last fall and resident uses wheel chair to get around now. Resident is afraid to ambulate by self. Interview with licensed staff A stated he/she did not investigate to rule out abuse or neglect of possible resident to resident altercation because resident would have told him/her. For residents #2 and #3, the operator failed to ensure the record contained a completed investigation to rule out abuse/neglect and report to administrator within 24 hours; immediate measure shall be taken to prevent further potential abuse/neglect while investigation in progress; thoroughly investigated within five working days of initial report; appropriated action shall be taken; the department's complaint investigation report shall be completed and submitted to the department within five working days of the initial report; and a written record shall be maintained of each investigation of reported abuse/neglect.	S3028		
S3155 SS=E	26-41-204 (a) Health Care Services	S3155		

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S3155	Continued From page 12 . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility identified a census of 31 residents. The sample included 3 residents. Based on record reviews, interviews, and observations for 2 (#2 and #3) of 3 residents sampled, the operator failed to ensure that a licensed nurse provided or coordinated the provision of necessary Health Care Services (HCS) that meet the needs of each resident and are in accordance with the Functional Capacity Screening (FCS) and the Negotiated Service Agreement (NSA). Findings included: - Record review for resident #2 revealed an admit date of 3-13-14 with diagnoses of brain injury from encephalitis. The FCS dated 11-5-15 recorded resident required physical assistance with bathing, dressing, transfer, toileting, bladder incontinence, communication, walking/mobility, experienced short-term memory loss, impaired memory recall, long term memory loss, impaired decision making, and falls/unsteadiness.	S3155		

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S3155	Continued From page 13 The NSA/HCS dated 11-2-15 recorded staff to provide physical assistance with dressing and grooming, resident is unsteady on feet at times because he/she moves too quickly, required one person assist with grooming and dressing tasks pulling pants up and down. Resident required one person assist with showering, toileting, changing protective undergarments, toilet resident every two to four hours during the day and as needed at night. Resident uses restroom often, usually related to anxiety. Resident required assist of one with transfers, uses walker for mobility, . . .and needs to be escorted while ambulating. Resident is very impulsive at times and restless at night due to brain injury. Resident demonstrates anxious disruptive or obsessive behaviors requiring additional attention. When resident demonstrates anxious behavior, staff are to take extra time with resident and involve resident in activities. Word search is a good distraction for anxiety. 8-10-16 at 1:20 p.m. faxed order noted to use gait belt with transfers and ambulation. The resident log recorded the following: 5-22-16 at 3:00 p.m. "Staff alerted this nurse to resident's bathroom. Resident was on the floor facing the door in a sitting position. Resident was in restroom with assistance from staff when resident attempted to remove shoes while standing. Resident hit left side of head on bathroom wall. Upon assessment no injuries noted at this time. NOTE: Post fall investigation documented resident attempted to stand and fell when staff left the resident alone in the bathroom while he/she went to the closet to get clothes.	S3155		

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6-10-16 at 4:25 a.m. "Notified by Certified Medication Aide (CMA) that resident had a witnessed fall. CMA was doing 4:00 a.m. rounds when he/she found resident on toilet. Resident went to stand up, lost balance falling backwards. Upon entry to room resident was sitting on bottom with feet in front of him/her. Resident stated hit back of head on wall. No open areas or complaint of headache/pain. "

6-17-16 at 2:45 a.m. CMA notified this nurse resident was on floor in room. Upon entry to room resident was seen on bathroom floor with legs out in front of him/her. Another resident had wandered into resident's room and took his/her walker. Resident was very anxious and other resident was led out of room by staff. Upon assessment no injuries are observed. Resident does complain of pain to right buttock.

7-18-16 at 12:10 p.m. This nurse notified family member and left message regarding a non-injury fall and to return call if had any concerns.

7-18-16 at 1:20 a.m. Resident had an unwitnessed fall. Resident was found sitting on floor by bathroom. Resident denied any pain at this time. Will continue to monitor.

7-22-16 at 8:06 p.m. This nurse was notified by phone of resident having an unwitnessed fall around 6:30 p.m. Upon assessment resident was ambulating with four wheeled walker independently. No injuries present.

7-23-16 at 1:00 p.m. Resident arrived back from the hospital at approximately 9:30 a.m. by Emergency Medical Services (EMS). Resident presents with a hematoma on the back of head

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approximately 3 Centimeters (CM) by 3 CM in a circular shape. Resident ' s hematoma purple in the middle with redness surrounding. Resident denied pain. Resident ambulated with four wheeled walker and is on fall follow up. Family notified.
(Record lacked documentation of the fall on 7-23-16.)

7-27-16 at 4:00 a.m. late entry for 7-26-16 at 2:15 a.m. was notified by certified staff working by phone. Resident was found on floor in bathroom. Resident ' s brief was wet and was sitting on bottom with feet out in front of him/her with back against wall next to toilet. Instructed certified staff to assist resident up with use of gait belt. Resident did not use walker when ambulating to restroom. Resident was reminded to use walker.

7-30-16 at 12:55 p.m. Resident standing at table in dining room with activity director and turned, lost balance landing on the floor between tables. Resident holding back of head and hematoma to occipital l lobe of head indicated from previous fall. Resident assisted up vital signs blood pressure 115/63, pulse 80, and respirations 17.

8-9-16 at 11:00 a.m. Resident had a witnessed fall at 9:20 a.m. Certified staff stated he/she was walking resident back to room and resident tripped over walker and fell face first to the floor. Resident had a laceration on his/her forehead above right eye. Resident complained of pain to forehead. Vital signs with in normal range. EMS called and resident was transported to hospital. Family notified, medical care provider notified.

8-9-16 at 2:46 p.m., " Resident arrived at 2:29 p.m. via family member. Resident had 5 stitches above right eye on laceration and noted

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hematoma above right eye 2.5 CM by 1 CM. Right eye has a purple color to it. Resident was assisted to room by wheelchair. "

8-21-16 at 10:20 p.m. Resident had an unwitnessed fall. This nurse was notified by certified staff that he/she came upon resident sitting on bottom on the floor at bedside. Resident stated, " fell on bottom ". Resident rubbing right leg, area assessed and put back in bed.

The NSA/HCS lacked interventions to address ongoing risk for falls. Review of post- fall investigation documents revealed repeated notes to remind resident to use call system and walker and increased frequency of monitoring.

On 9-7-16 at 4:00 p.m. observed resident in activity room sitting in chair with walker in front of him/her. Resident stood up and took few steps with walker then returned back to chair. No use of gaile belt observed. At 4:30 p.m. observed certified staff C ambulate resident to dining room from activity room using walker. No gait belt used.

Confidential interview on 9-12-16 stated resident #2 had several falls recently and concerned about what facility staff are doing to help prevent falls. Resident is found on the floor in room and has a roommate. Door is locked from outside while both residents in room alone. Most falls happen during the evening/night time. Resident #2 is not able to use a call light or remember to use walker.

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S3155	Continued From page 17 Interview on 9-12-16 at 11:00 a.m. with licensed staff B stated resident #2 is checked every two hours and resident is very impulsive. They try to keep resident busy with activities. Interview on 9-12-16 at 12:45 with licensed staff A stated and provided investigations of falls for resident #2. Licensed staff A stated the interventions on post-fall investigation are supposed to be added to the NSA and confirmed he/she had not added the interventions on post-fall investigation reports to the NSA. Licensed staff A stated resident was non-compliant with verbal commands and use of walker. Resident has a roommate and when residents in room the door is locked from the outside. Residents can open the door from the inside. Licensed staff A stated and confirmed the NSA lacked interventions for impulsive behaviors, falls due to not using walker, call light, required physical assistance with ambulation, use of gait belt, and to be checked on hourly. Licensed staff A confirmed resident experienced short-term memory loss, memory recall, impaired decision making, and experienced agitation/anxiety. Resident #2 experienced 11 falls, 2 falls required emergency transfer to the hospital, 1 fall required sutures, 3 falls with head injuries. For resident #2, the operator failed to ensure the licensed nurse provide and coordinate provisions necessary HCS for assistance with transfers, toileting, ambulation, falls/unsteadiness in accordance with the FCS and the NSA.	S3155		

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Second resident #3204(a)
- Record review for resident #3 revealed an admit date of 3-4-16 with diagnoses dementia and macular degeneration.

The FCS dated 3-4-16 recorded resident independent with toileting, transfer, communication, required physical assistance with dressing, bathing, incontinent of bladder, experienced short term memory loss, memory recall long term memory loss, impaired decision making and falls/unsteadiness.

The NSA dated 3-4-16 recorded staff will assist with dressing, bathing, resident occasionally incontinent of bladder and able to provide self-care for incontinence. Resident independent with ambulation with a walker and verbal direction. Resident has impaired short term memory, memory recall, long term memory loss and decision making. Staff will assist with daily. Memory impairment is reason for escort service.

Faxed medical care provider order dated 7-6-16 recorded:
Regarding (resident #3) has had two falls in twenty four hours, request urinalysis.

Hospital emergency department visit on 8-22-16 recorded Diagnosis: Accidental fall/ Acute UTI; Contusion of elbow left; Contusion of left hip; Contusion of left shoulder.

Resident log notes recorded the following:

6-28-16 (no time) Resident fell outside on the

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front patio. Fall was witnessed by activity coordinator and family member. Assisted resident up to stand. Physician notified.

6-30-16 at 4:15 a.m. At 4:00 a.m. a call light sounded and certified staff went to answer and requested assistance. Certified staff reported resident was on floor with walker. Resident found on floor in bedroom. Legs are bent and resident stated he/she is going to the bathroom. Resident #3 ' s roommate (resident #2) was on toilet and walker was in bathroom with resident #2. Resident #3 was checked for injuries and none noted. Resident does complain of left thigh pain. Resident able to move all extremities within normal limits. Vital signs blood pressure (B/P) 151/84, pulse (P) 69, respirations (R) 15, and temperature (T) 97.4. Physician faxed and requested an x-ray.

7-1-16 at 1:50 p.m. resident up ambulating with four wheeled walker.

7-5-16 at 9:06 p.m. Resident fell this morning in bathroom. Resident stated got up from the toilet and felt dizzy, lost balance and fell. Noted scrape to right knee 1CM by 1CM. No other injuries noted.

7-6-16 at 1:00 a.m. Resident had an unwitnessed fall. This nurse heard resident moaning while assisting another resident went to check on resident and found resident with torso on bed and knees on floor. Resident was attempting to get up by self. Resident has a bruise underneath right eye, quarter sized purple bruise to left lateral hip and skin abrasions to right knee. Resident able to perform range of motion with normal limits. Resident complained of pain to left shoulder. New order for physical therapy

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consult. This is second fall in 2 days.

7-7-16 at 5:26 a.m. Resident on fall follow up. Resident is assisted with one person assist at night to toilet every two hours and call light attached to shirt.

8-2-16 at 7:49 p.m. Resident had an unwitnessed fall in the dining room at 12:15 p.m. Resident was found lying on left side. When turning resident on back he/she complained of pain in left hip and lower back. 911 was called. While at hospital lab showed resident had a urinary tract infection (UTI). At 3:45 p.m. resident returned to facility with diagnoses of UTI.

8-3-16 at 4:00 a.m. Resident up ambulating with one staff assist and use of walker. Resident stated left thigh hurt, pain medication administered and will continue to monitor.

8-22-16 at 9:15 a.m. Staff heard resident yelling and alerted this nurse that resident was on floor. Resident was flat on back with head facing door. Resident denied hitting head and complained of pain with ROM to left hip; leg; back; and left elbow. No lacerations or hematoma ' s noted. EMS notified due to left hip; leg; and back pain.

8-22-16 at 12:45 p.m. Resident returned to facility by private auto and family. B/P 102/60, P 80, R 16, T 98.0. New order to have a follow up x-ray on left elbow in seven days.

Record lacked documentation of an x-ray of left elbow seven days after 8-22-16.

9-4-16 at 7:00 a.m. It was reported to this nurse that resident stated he/she had fallen during the night. Staff reported that at 3:00 a.m. they did

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rounds to toilet resident and resident was up in recliner in room and stated he/she had fallen while getting out of bed. ROM normal. Resident has a golf ball size bruising to left temple. Physician and family notified. Awaiting response.

The record lacked further documentation.

Observation on 9-7-16 at 4:05 p.m. of resident #3 noted propelling self in wheel chair. Observed a dark bruise to right temporal area of head. Resident rubbed area and stated it hurt. Resident further stated he/she did not know what happened. 9-12-16 at 12:30 p.m. observed resident with dark blue bruise to right temporal area the size of a tennis ball. Resident in wheel chair propelling self around dining area.

Interview on 9-12-16 at 12:40 p.m. with certified staff C stated the bruise is from last fall and resident uses wheel chair to get around now. Resident is afraid to ambulate by self.

Interview with licensed staff A stated he/she did not add interventions for falls to the NSA/HCS and confirmed the NSA lacked information to toilet resident every two hours at night; assist resident with toileting; and remind resident to use walker when up. Licensed staff A stated resident is checked hourly at night and confirmed hourly checks was not in the NSA/HCSP. Licensed staff a stated he/she did not investigate to rule out abuse or neglect of possible resident to resident altercation because resident would have told him/her.

Resident #3 experienced 6 falls, two required hospital emergency room visits by ambulance due to injuries. The NSA/HCSP lacked interventions for falls.

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S3155	Continued From page 22 For residents #2 and #3, the operator failed to ensure that a licensed nurse provided or coordinated the provision of necessary HCS that meet the needs of each resident and are in accordance with the FCS and the NSA.	S3155		