NOTICE OF INJURY
PURSUANT TO WIS. STAT. § 893.80

TO: Susan Ertmer
County Clerk, Winnebago County
Winnebago County Courthouse
415 Jackson Street, Room 110
Oshkosh, WI 54903-2808

SERVED BY: DAVID B. SQUIRES
NOV 11 2011

Margie Rankin, R.D., NHA
Administrator
Park View Health Center
725 Butler Ave.
Oshkosh, WI 54901

FILED
NOV 11 2011
COUNTY CLERK
WINNEBAGO COUNTY, WI

THE ABOVE-NAMED PARTIES,
PLEASE TAKE NOTICE:

1. Sarah Christianson, formerly of 5300 Ann Street, No. 109, Larsen, WI 54947 died on January 11, 2011 while in the care of Park View Health Center, 725 Butler Avenue, Oshkosh, WI 54901.

2. In addition to Rodney Christianson, who already filed a Notice of Injury/Claim pursuant to Wis. Stat. §893.80 (see Notice attached as Exhibit A) Daryl Christianson, 1699 Alcan Drive, No. 210, Menasha, WI 54952, and Howard Christianson, 1958 Timberline Drive, Oshkosh, WI 54904 are also heirs of Sarah Christianson and are entitled to claims against Park View Health Center for the loss of their mother. The Estate of Sarah Christianson is also entitled to damages.

3. On December 10, 2010 Sarah Christianson was checked into Park View Health Center for a temporary stay to room number Woodside 405-1S. Sarah Christianson was noted to have a high risk of falling. Approximately two hours later Sarah Christianson was found on the floor of her room with a broken hip. She was transported to Mercy Medical Center for the multiple hip fractures. She was readmitted to Park View Health Care Center where she ultimately died on January 11, 2011, due to complications from her broken hip.

4. The above named parties were negligent in preventing Sarah Christianson's fall when she had been identified as a resident with a high risk of falls. As a result of the above named parties' negligence Park View Health Care Center received a citation for a violation of Wis. Stat. §132.60 (1) from the State of Wisconsin Department of Health Services, Division of Quality Assurance (see copy of Notice attached as Exhibit B).

5. As a direct and proximate cause of the negligence of the above named parties Sarah Christianson suffered personal injuries and pain and suffering and Rodney, Howard and

Daryl Christianson were deprived of the relationship and companionship stemming from the wrongful death of their mother.

6. At all times material hereto, the parties had actual notice of the aforesaid incident and thoroughly investigated it.

7. This document is a Notice of Injury served on the above named parties in compliance with Wisconsin law.

8. A claim in this matter by Rodney Christianson has already been made in the amount of $50,000.00. More than 120 days have passed since that Notice was given on April 5, 2011.

9. Additional claims are being made on behalf of Daryl Christianson and Howard Christianson at this time, of the statutory limit of $50,000.00 each.

10. The total claim for the three heirs in this case is $150,000.00.

Dated this 10th day of November, 2011.

SCHOMISCH LEGAL GROUP, L.L.C.
Attorneys for Rodney Christianson, Daryl Christianson and Howard Christianson and the Estate of Sarah Constance Christianson

By: _____
John T. Schomisch, Jr.
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NOTICE OF INJURY/CLAIM PURSUANT TO WISCONSIN STATUE 893.80

To: Clerk of Winnebago County, 415 Jackson Street, Oshkosh, WI

Margie Rankin-Administrator, Park View Health Center, 725 Butler Ave., Oshkosh, WI

Incident Information

Person involved in incident: Sarah Christianson, patient at Park View
Incident Description: Broken hip due to fall and proximate to her death
Date/Time: December 10, 2010 at 20:30 per Park View notes
Place: Park View Health Center, room no: Woodside 405-1S

Circumstances of Claim

Sarah Christianson was admitted to Park View on Dec. 10 at 17:30 accompanied by her son/his wife, Rodney and JoNel Christianson. Rodney and JoNel left around 1 hour later and Sarah was alert/sitting in the cafeteria and feeding herself dinner. Rodney got a phone call at 20:30 stating that Sarah had fallen and was found on the bathroom floor in her room. She was transferred to Mercy Medical Center for treatment. Hip surgery for multiple fractures was completed on Dec. 11. She was readmitted to Park View on Dec. 14.

Park View was negligent in the care of Sarah which contributed to her death on Jan. 11, 2011. Her fall could have been prevented. Two key factors contributed to the fall: application of lotion to Sarah's feet prior to the fall which made her feet slippery increasing the risk of falling and use of ½ bedrails instead of the larger bedrails requested in writing prior to her fall by Rodney Christianson.

There are other details of the incident that are being investigated by Rodney Christianson et al. Park View has not been responsive in providing specific details of the incident.

Claim

The undersigned hereby makes a claim against Winnebago County in the amount of $50,000 which is the maximum amount specified in the Wisconsin statutes. The $50,000 claim is for the pain and suffering, loss of companionship, and hospital bills related to her fall.

Signed/Date: Rodney Christianson April 5, 2011

Name/Address: Rodney Christianson, 1958 Timberline Drive, Oshkosh, WI 54904
(Son of Sarah Christianson and her Power of Attorney)

Exhibit A

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2436	A. BUILDING _____ B. WING _____	C 06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW HEALTH CENTER	725 BUTLER AVE OSHKOSH, WI 54901

(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 This was a facility self-report and complaint survey conducted at Park View Health Center on 6/1/11. # of state citations issued: 1 Census: 162 Sample size: 15 Survey coordinator: #19439	S 000		
S 437 SS=B	132.60(8)(c) IMPLEMENTATION OF CARE PLANS Implementation. The care plans shall be substantially followed. This Rule is not met as evidenced by: Class B Date of Violation: 12/10/10 Date of Discovery: 6/1/11 Based on staff interview and record review, the facility did not substantially follow the care plan for 1 (resident #1) of 15 sampled residents. The facility implemented the use of bed and chair alarms for resident #1 on admission. Within three hours of admission, resident #1 sustained a fall with a fractured hip. The plan of care had not been substantially followed, as the bed alarm was not turned on, as directed by the plan of care. The facility's actions created a situation that was directly threatening to the safety and welfare of resident #1. Findings include: The face sheet, dated 12/10/10 and contained	S 437		

Exhibit B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 437	Continued From page 2 documented at 8:30 p.m. the resident was found on the floor with injury. Resident #1 had external rotation of the right leg with complaints of pain. The note documented resident #1 "...got out of bed unassisted", and the documentation indicated bedmate and chairmate alarms were implemented prior to the fall. The documentation noted the bedmate (alarm) was off at the time of the incident. Resident #1 was transferred and admitted to the hospital. The hospital discharge summary, dated 12/14/10, indicated resident #1 was admitted to the hospital on 12/10/10 following a fall at the nursing home with a sustained right hip fracture. Resident #1 was re-admitted to the facility on 12/14/10 after undergoing a trochanteric nail fixation of the right hip. On 6/1/11 at 2:30 p.m. surveyor #19439 interviewed RN (Registered Nurse)-B regarding resident #1 and the fall the resident sustained on 12/10/10. RN-B verified resident #1 was at risk for falls at the time of admission to the facility on 12/10/10. RN-B verified the use of alarms in the chair and in bed were implemented at the time of the resident's admission. RN-B stated prior to resident #1's fall on 12/10/10, the resident had been laying in bed. RN-B verified resident #1 attempted to self-ambulate at the time the fall occurred. RN-B verified the bed alarm was on the bed but was not turned on; and therefore, did not alert staff to unassisted movement by resident #1. RN-B verified the plan of care implemented at the time of the resident's admission included the use of the alarms in bed and chair. The RN verified the plan of care was not substantially followed, as the bed alarm was not turned on at the time of the incident.	S 437		

Wisconsin Department of Health Services

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S 437	Continued From page 4 completed.	S 437		