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	145597	A. BUILDING _____ B. WING _____	C 09/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEKIN MANOR	**1520 EL CAMINO DRIVE PEKIN, IL 61554**

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F 490	Continued From page 45 regarding the reporting requirement to IDPH for serious incidents and accidents (8/25/06). 9. All nurses were interviewed regarding any serious incidents or accidents within the past two weeks. Any identified incidents or accidents will be fully investigated and reported. (8/25/06). 10. The facility incident log for the past month has been reviewed. No incidents or accidents were identified that had not been report that should have been. (8/25/06). 11. All nursing staff was in serviced on reporting serious incidents or accidents (8/25/06).	F 490		
F9999	FINAL OBSERVATIONS Licensure Violations 300.510e) 300.610a) 300.160c)2) 300.690a)1) 300.690a)2) 300.690b) 300.690c) 300.1210a) 300.1210b)6) 300.1220b)1) 300.1220b)2) 300.1220b)3) 300.1220b)6) 300.1220b)7) 300.1220b)8) 300.1220b)9) 300.1810b) 300.1880e)5) 300.3240a) Section 300.510 Administrator e) The licensee and the administrator shall be	F9999		

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F9999	Continued From page 46 familiar with this Part. They shall be responsible for seeing that the applicable regulations are met in the facility and that employees are familiar with those regulations according to the level of their responsibilities. 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. c) These written policies shall include, at a minimum the following provisions: 2) Resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic service (including laboratory and x-ray). Section 300.690 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis	F9999		

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F9999	Continued From page 47 shall be reported to the Department. 1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by a phone call to the Department's toll-free complaint registry number. 2) A narrative summary of each accident or incident occurrence shall be sent to the Department within seven days of the occurrence. b) A descriptive summary of each incident or accident shall be recorded in the progress notes or nurse's notes for each resident involved. c) The facility shall maintain a file of all written reports of serious incidents or accidents involving residents. 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) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 6) All necessary precautions shall be taken to 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	F9999		

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F9999	Continued From page 48 Services b) The DON shall supervise and oversee the nursing services of the facility, including: 1) Assigning and directing the activities of nursing service personnel. 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. 6) Developing and maintaining nursing service objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing personnel. 7) Coordinating the care and services provided to residents in the nursing facility. 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 49 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. 9) Participating in the development and implementation of resident care policies and bringing resident care problems, requiring changes in policy, to the attention of the facility's policy development group. (See Section 300.610(a)). Section 300.1810 Resident Record Requirements b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives. Section 300.1880 Other Facility Record Requirements e) Rules located in other Sections of this Part that pertain to the content and maintenance of facility records are as follows: 5) The facility shall maintain a file of all reports of serious incidents or accidents involving residents as required by Section 300.690 of this Part. 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 regulations are not met as evidenced by the following: Based on observation, record review, and	F9999		

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F9999	Continued From page 50 interview the facility failed to: a) investigate similarities in incidents involving side rails and low air loss mattresses for 3 of 3 residents (R1,R2, R3), b) assess the need for siderails before implementation of their use for 3 of 3 sampled residents (R1, R2, R3), c) reassess the continued need for siderails after implementation of a Low Air Loss mattress for 3 of 3 sampled hospice residents (R1, R2, R3), d) follow their own policy/procedure for incident reporting and resident follow-up following the incidents, e) have policies/procedures in place regarding optimal inflation of the air loss mattress and overall assessment of siderails in use with this mattress, f) utilize the manufacturer's recommendations/specifications for the safe use of the low air loss mattress and provide staff training on the use of the Low Air Loss mattresses, g) report significant injuries requiring outside services to the Illinois Department of Public Health for 1 of 3 residents. (R2), h) provide orientation to new employees on the facility's policies and procedures, i) provide new employees training on the computer generated incident reporting system and have a system in place for the integration of hospice services, j) follow their policy and procedure when outside equipment is brought to the facility for use by residents, k) follow their policy and procedure by maintaining records for Department Head Meetings, Quality Assurance Committee, Safety Committee and Resident Documentation, and l) have guidelines in place for identification of	F9999		

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F9999	Continued From page 51 coroners cases. R3 suffered a bruised, swollen and displaced nose after hitting her face against the siderails. R2 was sent to the hospital after staff found her with her head and neck caught in the siderail. R1 was found by facility staff with her neck caught between the side rail and the low air loss mattress. On 8/25/06 at 3:52 pm, Z2 (coroner) stated, "(R1) died from asphyxiation from hanging on the siderail." Findings include: 1) The physicians' orders dated 8/16/06 for R1 show initial admission date of 10/26/05 with diagnoses including: Dementia, Cachexia (malnutrition), Diabetes and history of heart attack The most recent Minimum Data Set (MDS) dated 7/19/06 identifies R1 weighed 145 pounds and was 5 foot 3 inches tall. R1 is identified as having severe cognitive deficits. R1 is described as totally dependent on staff for: a) bed mobility b) transfers c) movement within the facility in a wheelchair d) dressing e) hygiene and f) bathing. On 6/23/06 hospice notes show R1 was placed on hospice. The admission hospice notes dated 6/23/06 confirm R1 was dependent on staff for all cares. The contracted hospice agency provided R1 with a Low Air Loss (LAL) mattress as a comfort measure. The LAL mattress can be inflated from a soft to firm setting. There are 9 different settings the LAL mattress can be set ranging from soft (light indicator on the left side of machine) to firm (light indicator on the right side of the machine).	F9999		

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F9999	Continued From page 52 On 8/28/06 at 1:00 pm Z2 (Hospice coordinator) stated, "We provide residents with the LAL (low air loss) mattress for comfort when they are approved for hospice. If a facility doesn't have a low bed we will provide it. They (facility staff) need to assess each person." Section I of the hospice contract dated 8/2000 part E "Facility Services" states the facility is responsible for, ". . . supervising and assisting in the use of any durable medical equipment and therapies." There was no setting specified in R1's medical record to show what inflation setting was required for the low air mattress to maintain a safe environment for R1. On 8/24/06 at 3:00 pm E1 (Administrator), E19 (Corporate nurse) and E20 (corporate nurse) were unable to state what air level R1's mattress had been set at. On 8/25/06 at 3:05 pm E19 stated, "Hospice does not give directives on the air pressure settings for the beds. They are inflated to the comfort of the resident." On 8/24/06 at 4:00 pm E1 (Administrator) was unable to locate an instruction manual for the use of the LAL mattress. The mattress manufacturer faxed a one-page document titled "Care and Cleaning" to the facility. Two manuals were subsequently downloaded from the company website by the Illinois Department of Public Health (IDPH) staff. The user manual obtained from the manufacturer of the Low Air Loss (LAL) mattress website shows the mattress measures 80 inches long by 35 inches wide by 10 inches deep when inflated. Page 3 of the Operator's Manual for the Low Air	F9999		

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F9999	Continued From page 53 Loss Mattress states "...mattresses are not intended to be and DO NOT FUNCTION AS a patient fall safety device. SIDE RAILS MUST BE USED WITH THE ...MATTRESS TO PREVENT FALLS, unless determined unnecessary based on the facility protocol or the patient's medical needs as determined by the facility, IN WHICH CASE THE USE OF OTHER SUITABLE PATIENT MEASURES ARE RECOMMENDED." Page 5 of the manual titled "Low Air Loss Mattress system" states, "It is recommended that the lowest setting that prevents bottoming-out be used.....a heavier resident will require a higher inflation." On 8/24/06 random beds utilizing the Low Air Loss mattresses (LAL) were observed. The Low Air Loss mattress was observed being utilized in three different types of bed frames. The different types of beds were discussed with E19 on 8/25/06 at 3:05 pm. E19 was unaware which beds, if any, had been provided by hospice. R1's bed measured 84 inches in length from headboard to footboard with upper rails on both sides of the bed measuring 27 inches in length. Each rail measured 11 inches in height with a parallel crossbar in the middle leaving a 5½ inch space. R1's bed frame was the only one utilizing this particular bed frame with the Low Air Loss (LAL) mattress. A 2 inch gap existed between the left side of the mattress and the left rail. A ¾ inch gap existed between the mattress and the right side rail which increased to 2½ inches when E19 (Corporate nurse) lay down in the bed. On 8/25/06 at 5:05 am the bed frame in use by R2 at the facility measured 78 inches long from headboard to footboard. A LAL mattress was on	F9999		

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F9999	Continued From page 54 R2's bed. The setting was at 80% inflation (7th light from the left). There was no setting for the inflation specified for the LAL mattress on R2's medical record or the care plan. The bed frame in use by R2 at the facility measured 78 inches in length from headboard to footboard. The rails on this bed were 22 inches in length with a height of 9 inches with a parallel crossbar in the middle leaving a 4½ inch space. The bed frame in use by R3 was a standard hospital bed. This bed was removed before head to foot board measurements were completed. A LAL mattress was on R3's bed. Full side rails were up while R3 lay in bed with the mattress inflated to 80% (7th light from the left). Half side rails were not possible with this type of bed. The space between the bed and the bed rail measured 4 inches on the left side of the bed and 2 ½ inches on the right side of the bed. 2) Nursing notes dated 8/4/06, 8/21/06, and 8/24/06 document three incidents where R1 was "found" with portions of her body either out of bed or partially out of bed. 8/4/06 Nursing notes by E10 (Licensed Practical Nurse/LPN) on 8/4/06 at midnight document the first incident: "CNA found resident with upper half of body on bed and twisted feet on floor with right leg resting against geriatric chair." E10 stated (in interview on 8/25/06 at 6:04 am), "On 8/04/06 (R1) had not completely fallen out of bed - her feet were against the geriatric chair. There were no bruises at that time so I documented she had red marks on her feet in case a bruise showed up later. She had a body	F9999		

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F9999	Continued From page 55 alarm on at the time but she didn't travel far enough to disconnect the cord from the base." E10 confirmed he had not initiated a fall event (for incident on 8/4/06), had not notified the physician and had not notified the family. On 8/29/06 at 5:31 am E17 stated, "I remember the night (8/4/06). One leg was on the bed. The other was stuck on the geriatric chair. Her face was against the rail. The (personal) alarm was on but not sounding." 8/21/06 Nursing notes on 8/21/06 state, "Resident found at 3:30 am against the bed." The incident report notes the body alarm was on and intact and states the care plan was reviewed and revised as needed on 8/21/06 at 4:37 pm. An approach was added on 8/21/06 to the care plan stating, "Night light on in room to aid staff when making frequent room checks." The last bed check had been done at 2:30 am on 8/23/06 by E11. (90 minutes prior to R1's death.) E17 (CNA) stated on 8/29/06 at 5:31 am (regarding incident 8/21/06), "(R1's) butt was half on/half off the bed. Her left arm looked like it was bruised from the rail. Her body alarm was still attached but it hadn't gone off." 08/23-24/06 Nursing notes on 8/23/06 document the following: "4:00 am (R1) was found by a Certified Nursing Assistant (E8/CNA) with her feet and lower body 1/2 off the bed and her head "hooked" at the neck on the bed rail. The Licensed Practical Nurse (E10-LPN) assessed R1 who was found not breathing and having no heartbeat."	F9999		

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F9999	Continued From page 56 E10 stated (in interview on 8/25/06 at 6:04 am), "When I went into the room (on 8/24/06), (R1's) feet were completely off the bed. I believe her butt to her knee was still on the bed. Her head was between the mattress and rail. Her chin was tipped back. I decided to put her back in bed. I last saw (R1) when I spoke to her roommate. The aides said they saw her about 1½ hours before it happened. I was not really trained about what to do with the bodies if they may be a coroner's case. I have worked here just over a year." When asked if any other resident has been caught in the siderails in a similar manner E10 stated, "I don't remember it happening to any other resident. I would have been told in report but nothing stuck in my mind." E10 stated he was unaware of any policy indicating how often a nurse should make rounds on residents. E1 and E20 confirmed there was no policy stating how often nurses should make rounds on residents on 8/25/06 at 1:35 pm E8 (CNA) stated in interviews on 8/24/06 at 5:00 am and 8/25/06 at 5:42 am, "I was helping another CNA (E11) do bed check. I went into (R1's) room. All I saw was her (R1's) head. When I went over to the bed her neck was between the rail and mattress. I went over to her and said her name but there was no response. I touched her and she felt cold. I went to the door and yelled for (E11). (E11) got the nurse and told me not to touch her. She had a personal alarm on but it had not disconnected so it wasn't ringing. I was only on that hall for last bed check so I didn't see (R1) earlier that night. She usually did not move on her own. No one else has gotten their head caught in the rail before that I know about."	F9999		

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F9999	Continued From page 57 E11 (Certified Nursing Assistant/CNA) stated on 8/25/06 at 5:20 am, "I was assigned (R1) the night she died. I was in her room at 2:30 am. I was doing bed checks. I turned her to change her and then put her on her back. About 4:00 am, E8 (CNA) went into (R1's) room during rounds." (90 minutes since last observation). "When I went in (R1) was sitting on the floor so I got the nurse (E10). When I went in with (E10) the bottom half of her body was on the floor and her neck was in between the mattress and the rail with her chin resting on the rail. Her body alarm was attached to the side rail on the side she fell out." When asked if any other resident has been caught in the siderails in a similar manner E11 stated, "This has not happened before that I am aware of." E8, E10 and E11 all stated in interviews on 8/25/06 that R1 was wearing a personal alarm at the time of the incident but (R1) had not stretched the cord enough to disconnect it from the base and was therefore the alarm was not sounding. E1 (Administrator) stated on 8/24/06 at approximately 3:00 pm, "The personal body alarm worked when I pulled it apart. It just had not been stretched enough." E9 (CNA) was interviewed on 8/24/06 at 5:15 am and stated, "(R1) would rarely say anything. (R1) might say 'ow' when we would roll her. When the bed is inflated (low air loss mattress) the bed is full and easy to slide off." E5 (CNA) and E6 (CNA) stated on 8/24/06 at 9:00 am, "The mattresses can be slippery. As long as you put the resident right in the middle it is ok because they won't slide. (R1) couldn't move on her own. We had a hard time moving	F9999		

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F9999	Continued From page 58 her." E5 and E6 further stated, "I don't know if there are set settings for the (LAL) mattresses and each resident." E8 stated on 8/25/06,"She (R1) usually did not move on her own." E15 (CNA) stated on 8/25/06 at 6:25 am, "I don't remember if she used the rails or not. It was rare." E16 (CNA) stated on 8/25/06 at 6:28 am,"(R1) would hold the rails if I put her hand on it. She would not necessarily pull. She pretty much stayed in one place until we helped her move." The care plan dated 4/20/06 was reviewed. The care plan does not address the use of the personal alarm. No updates were noted on the care plan regarding the use of the personal alarm, how to do ensure the cord was in an appropriate position or how often the personal alarm should be checked by facility staff for functioning. Under "Falls" the care plan shows "siderails up to aid with positioning." On 8/24/06 at 9:30 am a siderail assessment for R1 was requested from E1 (Administrator). On 8/24/06 at 3:30 pm, E19 provided a siderail assessment with a "recording date" of 8/23/06 at 11:50 am (8 hours after R1 died). This assessment notes R1 experienced the following: a) alteration in safety awareness due to cognitive decline b) a score of greater than 10 on the fall assessment indicating resident at high risk for falls c) demonstrated poor bed mobility and/or difficulty moving to a sitting position on the side of the bed d) difficulty with balance and/or poor trunk control and e) resident currently using	F9999		

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F9999	Continued From page 59 siderails for position and/or support. On 8/25/06 E19 was unable to provide an updated assessment for when the Low Air Loss mattress was initiated or subsequent siderail assessments for R1 prior to her death on 8/23/06. Under the section "Risk for skin breakdown" the 4/20/06 care plan states, "Encourage and assist resident as needed with turning and positioning as needed (PRN)" and "siderails up to aid in turning and repositioning." These areas of the care plan were last reviewed by E19 on 7/27/06 and state, "Problem and approaches reviewed no changes." E19 stated on 8/25/06," R1 would use the rails to move in bed." 3) The physicians' orders for R2 dated 7/1/06 show initial admission date of 3/21/06 with diagnoses including: Congestive Heart Failure, Esophagitis, Anxiety and placed on Hospice on 6/9/06. The Minimum Data Set dated 6/22/06 shows R2 was 5 foot 4 inches and weighed 125 pounds. R2 had been placed on a Low Air Loss (LAL) mattress on 6/9/06 when hospice services were initiated. R2 was observed in bed on 8/24/06 at 2:30 p.m. and 8/25/06 at 5:05 a.m. with the setting at 80% of full inflation. No setting for safe inflation of the LAL mattress was found on R2's medical record. Emergency medical transport log dated 6/20/06 at approximately 1:00 am shows transport was called to the facility to transport R2 to a local hospital for evaluation of "possible strangulation." This report states, "Staff at ECF (extended care facility) stated patient was found next to her bed with her buttocks on the floor and her head	F9999		

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caught in between the mattress and bed rail. (ECF) staff stated patient appeared to be 'strangling' in that position. Staff put her back in bed and contacted hospice who requested she be taken to the emergency department (ED) for evaluation."

On 8/24/06 an incident report was requested from E1 regarding R2 on 6/20/06. During daily status meeting on 8/24/06 at 5:00 pm, E1 stated she had not been informed of the incident and a report had not been generated to Illinois Department of Public Health (IDPH) and an investigation had not been completed.

The nursing notes for 6/19/06 through 6/21/06 were reviewed. There is no notation in the medical record by staff relating R2 had been found hanging by the rail or was sent to the hospital for evaluation. There is no record showing the physician had been notified of the incident.

E12 (LPN) confirmed, on 8/29/06 at 12:25 pm, that he had not generated an incident report to the facility administration and stated, "I think I charted it in the nursing notes. I was not familiar with the computer. The other nurse was assigned to (R2). I didn't fill out a report. I would have thought or hoped she (E13/LPN) would have filled it out. I didn't know a report had to be filled out or that the Director of Nurses (E7) needed to be told. I got 1½ days orientation - that was all. The report (incident) comes from the computer and I didn't find out till later it (report) even existed." E12 (LPN) stated that he was employed at the facility from June 2006 until 8/16/06. E12 further stated, "I remember the night (R2) got tangled in the bed rail. The 3rd

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shift CNA came out. (R2) had rolled to her right side and fallen out of bed. Her head was caught in the rail. We went in and grabbed her out. She had a red mark on her neck. I was going to call 911 but (E13/LPN) said to call hospice. I called hospice and they said not to send her to the hospital. The hospice nurse came and looked at her and told us to send her to ED. I had not worked that hall so I didn't know (R2) well.

The hospice note for the on-call hospice nurse (Z3) who responded at 12:30 am on 6/20/06 was not found on the medical record of R2. This note was obtained from Z2 (Hospice nurse) on 8/28/06. This note, written by Z3 on 6/20/06 at 12:05 am, states "Call received from triage nurse to visit [facility] regarding patient hanging from bed." At 12:30 am Z3's notes state, "Arrived at nursing home...Staff nurse reported patient was in low position when 'hanging' occurred...An approximate 2 centimeter (cm) line indentation noted under right side of chin - area slightly reddened - arms bruised....Daughter and (hospice) recommendation patient be sent to (ED) for follow up evaluation. Staff nurse earlier stated 'CNA reported around midnight - patient was hanging from her bed (right) rail and the CNA was unable to free her. Patient was saying 'help me, I can't breathe.'"

E21 (CNA) stated in interview on 9/1/06 at 1:00 pm that she was the staff member who found R2 in the early hours of 6/20/06. E21 stated, "I remember the night I found (R2) - not the exact date but it is something I won't forget. I couldn't get her out of the rail. She was pretty stuck. Her neck was caught between the bed and the rail. Her butt was on the ground. I ran to get the nurse. I couldn't find anyone so I started yelling

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and hollering for anyone. I would run back to check on her - she was calling help me in a faint voice. Finally the other CNA came to help and the nurse came. It seemed like forever before they came to help me but it was probably 4-5 minutes."

On 8/29/06 at 5:50 am E17 (CNA) stated, "I remember (R2) was sent to the hospital. (E21) was working and she (E21) had that hall. She found (R2) stuck in the rails. She came and got me and I went and got the nurse (E12). (R2) was complaining her neck hurt. The three of us tried to get her released. We put her to bed and she still said her neck hurt. She had a little dent in her throat. The hospice nurse came out and we sent her to the hospital."

The care plan for R2 dated 3/21/06 with last evaluation date of 6/29/06 shows siderails being utilized. No interventions had been added addressing the incident of 6/20/06 to increase safety and prevent R2 from getting caught in the siderails.

On 8/25/06 at 2:35 p.m. E19 was unable to provide an initial siderail assessment, an updated assessment when the Low Air Loss mattress was initiated or subsequent siderail assessments for R2 dated prior to 8/24/06. The 8/24/06 assessment showed R2 experienced the following: a) poor bed mobility and/or difficulty moving to a sitting position on the side of the bed b) difficulty with balance and/or poor trunk control c) was on medication which would require increased safety precautions d) currently using side rails for position and/or support e) resident has expressed a desire to have side rails raised while in bed.

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F9999	Continued From page 63 On 9/1/06 at 1:00 pm E21 (CNA) stated, "I don't think she used the rails to move." 4) Physicians' orders for R3 dated 6/28/06 show initial admission date of 8/10/04 and diagnoses including: Cerebral Vascular Accident (stroke), Hypertension and Depression. A late entry in the nursing notes dated 6/3/06 states, "Late entry for 6/2/06 am. Nose slightly bruised, slightly displaced and swollen. States when turned hit face on siderail. Did not report to nurse at time." An incident report was requested for this date. On 8/25/06 E1 (Administrator) provided an incident report dated 6/8/06. This report had been generated by E7 (former Director of Nurses). No report initiated by the nurse on duty at the time of the incident was provided by the facility. The careplan for R3 shows initiation of siderails on 4/8/05 to aid in positioning. No update has been done since the initiation of siderails. The careplan does not specify if full or half rails are to be utilized. On 8/25/06 at 9:30 am a siderail assessment was requested from E1 (Administrator). On 8/24/06 at 3:30 pm E19 (corporate nurse) provided an assessment for R3 with a recording date of 8/24/06 at 9:23 am. E19 was unable to provide any siderail assessment prior to the initiation of siderail use, after the implementation of the Low Air Loss mattress or subsequent assessments dated prior to 8/24/06. POLICY AND PROCEDURE ISSUES:	F9999		

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F9999	Continued From page 64 A) Orientation of Staff to facility equipment and policies On 9/1/06 at 9:15 am E18 (Registered Nurse/RN) stated, "I really got no orientation to facility policies. I worked on the floor with another nurse. I was not really confident in using or accessing anything in the computer except for nurses notes. I needed additional help from the other nurses." On 9/1/06 at 8:20 am E7 (former Director of Nurses) stated, "I did the LPN/RN training. The nurses got three days more of a 'hands on' training. There is a policy/procedure manual at the nurse's station. I didn't have them read each policy when they hired on - it was dry." B) Incident Reporting On 9/1/06 E7 stated, "Any incident report that is filled out generates a report that is sent to administrative staff or if an order to send a resident (is obtained) a report is sent. When administration turns on their computers in the morning, the computer says 'list messages'; this list contains information of accidents/incidents or hospital visits. If she (R) was sent to the hospital we would have known. Then we would have had to look at the record to see what happened." On 8/25/06 E1 provided a copy of the Facility Policy dated 2/04 and titled 'Accident and Incident Reporting' under the heading "Objective" states "To document all accidents/incidents occurring to residents." Under "Procedure: Resident" this policy states "b) notify the nurse who then must notify Physician and Family. c) If there has been no apparent injury, follow-up must continue for 24 hours. d) If there is apparent or suspected injury, follow-up must continue for at	F9999		

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least 72 hours. e) Documentation must be on Accident and Incident Reports as well as in the Nurses Notes. Section 4 of the facility policy for "Accident and Incident Reporting" states "In all cases: a) There must be an exact description of the accident/incident including: Location, time, date, witnesses and statements if any, level of consciousness, description of any emergency care given, vital signs for residents and any persons notified of the incident.

The nurses notes fail to document at least a 24 hour follow up after R1 ' s incidents on 8/4/06 and 8/21/06.

C) Hospice Services and Coordination of Services
On 8/59/06 a policy and procedure for the integration of hospice services was requested from E1. At 1:35 pm on 8/25/06, E1 and E19 (corporate nurse) stated no policy existed for an integration of services.

The hospice contract dated 8/2000 section II subsection C. "Monitoring and Evaluation: Administrative personnel from the Facility and from the hospice shall meet regularly to: 1) Facilitate cooperative efforts between the Hospice and the Facility in providing care for Hospice patients; 3) Review, as necessary, on an informal basis, any additional issues of concern to the parties to this agreement.

Z2 (hospice coordinator) stated on 8/28/06 at 1:00 pm, "Any time we visit a nursing home we leave a note - at least within 24 hours. We didn't see a note from the home. When staff told me there was no note relating to (R2's) neck getting caught, I told them (hospice staff) they needed to

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let the facility know and follow up with the Director of Nurses (E7). We leave notes to facilitate communication. My staff told me that had talked to (E7). The problem we have is not having access to notes in the computer."

D) Documentation Issues
Facility policy #3.03 "Resident Documentation," dated 12/03, states: "Policy - The facility shall maintain responsible and accurate documentation on all residents through proper usage of Nurse Aid/Orderly Daily Documentation Checklist; Nurses' Notes, and Monthly Documentation Summaries." Under the section "Procedure - Resident Daily Documentation Checklist Nurse Aide/Orderly" this policy states: "Proper usage - Each area on the Nurse Aide/Orderly Daily Documentation Checklist must be documented on each 8 hour shift but the Nurse Aide/Orderly assigned to the resident that shift. On the back of each Nurse Aide/Orderly Daily Documentation Checklist are Nurses' Notes. These are to be used by the Nurse Aide/Orderly to document additional or more specific information.....All documentation on the Nurse Aide/Orderly Daily Documentation Checklist must be done on a timely and accurate basis."

On 8/25/06 the Nurse Aide/Orderly Daily Documentation sheets for R1, R2 and R3 from 5/06 - 8/06 were requested from E1. On 8/25/06 E1 stated none of these documents could be located. On 8/29/06 E1 confirmed these documents could not be located.

E) Policy for Coroner's Cases
On 8/25/06 a policy regarding the identification and procedure for the care of a resident who was

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F9999	Continued From page 67 a coroner ' s case was requested. On 8/25/06 and 8/29/06 E1 stated no policy existed. (A)	F9999		