STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

CHESTNUT MANOR	0009958
Facility Name	I.D. Number
1404 SOUTH 14TH STREET, HERRIN, ILLINOIS 62948	
Address, City, State, Zip	
02509, 18196	AUGUST 8, 2008
Reviewed By	Date of Survey
ANNUAL	10072, 15478
Type of Survey	Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

350.620a)
350.1220e)
350.1220j)
350.1220k)
350.1230a)3)
350.1230b)2)3)6)7)
350.1230c)
350.1230d)
350.1230g)
350.3240a)

Section 350.620 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

Section 350.1220 Physician Services

a) The facility shall have a written program of medical services that reflects the philosophy of care provided, the policies relating to this, and the procedures for implementation of the services. The program shall include the health services provided by the facility and the arrangements to affect a transfer to other facilities as promptly as needed. The written program of medical services shall be followed in the operation of the facility.

e) All residents shall be seen by their physician as often as necessary to assure adequate health care.

j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.

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k) At the time of an accident, immediate first aid treatment shall be provided by personnel trained in medically approved first aid procedures.

Section 350.1230 Nursing Services

a) Each facility shall have a full-time director of nursing services (DON) who is a registered nurse (RN) and whose only responsibility is the immediate supervision of the facility's health services. This person shall be on duty a minimum of 36 hours, four days per week. At least 50 percent of this person's hours shall be regularly scheduled between 7 A.M. and 7 P.M.

3) In facilities with a capacity of fewer than 50 beds, this person (or these persons) may also provide direct patient care, and this person's time may be included in meeting the staff to resident ratio requirements.

b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in:

2) Evaluation study, program design, and placement of the resident at the time of admission to the facility.

3) Periodic reevaluation of the type, extent, and quality of services and programming.

6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program.

7) Modification of the resident care plan, in terms of the resident's daily needs, as needed.

c) A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel.

d) Direct care personnel shall be trained in, but are not limited to, the following:

1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.

2) Basic skills required to meet the health needs and problems of the residents.

3) First aid in the presence of accident or illness.

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g) Nursing service personnel at all levels of competence and experience shall be assigned responsibilities in accordance with their qualifications.

Section 350.3240 Abuse and Neglect

a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.*

These Regulations were not met as evidenced by:

Based on observation, interviews and record review, the facility failed to ensure that clients receive nursing care in accordance with their needs for 2 of 4 clients in the sample (R1 and R3) and 1 outside the sample (R5) who have recently been diagnosed with: 1) cerebral vascular accident resulting in dysphagia and fine motor skill weakness (R1), 2) prostate cancer with complaints of stinging upon urination (R1), 3) decubitus ulcer on the coccyx with no documented repositioning occurring (R3) and 4) falls resulting in 3 fractures to the left ankle (R5).

The facility failed to:

1) Ensure a monitoring system is in place for clients with a recent history of falls, cerebral vascular accident and decubitus. (R1, R3 and R5)

2) Develop and implement an aggressive plan for fall prevention. (R5)

3) Develop and implement an aggressive prevention plan for maintaining skin integrity, inclusive of reassessment, repositioning and documentation including staging of open areas. (R3)

4) Develop and implement a plan of care reflective of a resident's health status and medical needs. (R1, R3 and R5)

5) Ensure that all assessments are updated and present an accurate assessment. (R1, R3 and R5)

6) Ensure that physician's orders are implemented as ordered. (R1 and R5)

7) Ensure timely assessment and treatment for residents' complaints of pain. (R1 and R5)

8) Ensure that residents are provided with adaptive equipment in accordance with their needs. (R5)

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9) Ensure that a nursing assessment is completed after a resident is released from the hospital. (R1 and R5)

10) Ensure that the IPP is updated to include all aspects of the client's health. (R1, R3 and R5)

Findings Include:

1. Per review of R5's Admission sheet dated 09-27-91, R5 is a 64 year old female who functions at a Severe level of mental retardation. Other diagnoses include: Congenital Syphilis, Defuse osteoporosis, Epilepsy, Peripheral Ulcer Disease, Cerebellum degeneration, Anemia and Edema.

Based on review of R5's Inventory for Client and Agency Planning (ICAP) dated 11-14-07, R5 functions at an overall age equivalent of 5 years and 7 months.

Surveyor reviewed R5's history of falls and noted that 02-16-07, R5 fell and fractured her right hip which required surgical intervention. R5 fell again on 04-16-07 and sustained a fracture to her left ankle which also required surgical intervention.

Per review of the facility's incident and accident reports, documentation states that on 04-30-08 at 11:58 a.m., R5 fell while at the local day training site sustaining a red area below her right elbow.

Upon review of documentation in R5's Direct Care Staff Notes, on 05-06-08 at 8:30 p.m., "Staff went to assist resident up and resident refused to stand on left foot. Staff noticed left foot was a little swollen and bruised...." Documentation continues to say that the Registered Nurse was contacted and R5 was taken to the local emergency room by ambulance. Documentation is signed by E7 (Direct Support Person).

Direct Care Staff notes on 05-06-08 continue to say, "Resident was evaluated at (local hospital) - X-rays were taken. X-ray showed 3 breaks in left ankle. Orthopedic surgeon notified, stated for resident to be admitted to hospital for further eval. in a.m. to determine if surgery is needed at this time." Documentation is signed by E7.

The hospital report dated 05-07-08, documentation states, "Apparently she fell sustaining a trimalleolar fracture of her left ankle. The patient has a history of multiple falls...."

The report continues to say that R5 has a history of edema of the lower extremities and will require surgical intervention. "The patient will require generous parenteral analgesics for pain control. We can expect her behavior to remain combative if we do not have adequate pain control." Documentation is signed by E9 (facility's medical director).

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Hospital reports, dated 05-10-08 state that on 05-07-08, R5 had an open reduction internal fixation of bimalleolar ankle fracture. R5 remained in the hospital and was released back to the facility on 05-10-08.

Nurses notes dated 05-10-08 at 1:00 p.m. state, "Res. was released from (local hospital), returned to facility by ambulance. Res. has a catheter at this time. Hosp. recommended for it to stay in until her 2 week check-up...." "...Res prescribed Cogentin 1 milligram tab at bedtime for 30 days. Haloperidol 2 milligrams 1 tab bid (twice daily) for 60 days, Oxycontin 10 milligrams 1 tab bid for 60 days...." Documentation is signed by E8 (Direct Support Person).

There is no evidence that the nurse (E3) assessed R5 following her release from the hospital until 05-13-08. (R5 returned to the facility with a surgical wound and urinary catheter).

Nurse Notes dated 05-13-08 at 4:15 p.m. states, "Foley catheter removed without difficulty. 150 cc dark yellow urine noted in catheter bag. Cast and ace wrap intact to left lower leg and arm. Fingers left hand are discolored and swollen as are the toes...." Documentation is signed by E3. (Registered Nurse Consultant).

There is no evidence that the nurse provided a plan of care for staff to assess circulation in R5's hand and toes, or that catheter care was implemented while R5 had a urinary catheter. In addition there was no plan in place to monitor R5's urinary function after the catheter was removed.

R5's post-operative orders from the orthopedic surgeon dated 05-08-08 include: "Keep affected extremity elevated", "Strict Decubiti and DVT (Deep Vein Thrombosis) precautions and Non weight bearing."

R5's discharge orders from the local hospital dated 05-10-08 state, "Weigh yourself daily and keep track of the weight. If you notice a weight gain of more that 2 pounds in 1 to 3 days or 5 pounds in a week, please contact your physician and follow his/her instructions. Take your pain medication if prescribed. Take it before the pain becomes severe enough to interfere with your activities. Call your physician if your pain is not controlled." Signs and Symptoms to report include: Increased swelling of legs and unusual increase in shortness of breath.

Medications that were ordered for R5 upon discharge from the hospital on 05-10-08 are: Oxycontin 10 milligrams every 12 hours, Haldol 2 milligrams twice a day, Benztropine 1 milligram at bedtime and Tylenol 650 milligrams every 4 hours as needed for mild pain. Documentation is signed by E8 (Direct Support Person).

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Per interview with E2 (House Manager) on 07-24-08 at 4:15 p.m., E2 stated that when R5 was released back to the facility on 05-10-08, the facility used the Orthopedic Post-Op Orders dated 05-08-08 and signed by Z4 and also the hospital's discharge instructions dated 05-10-08.

When asked about the strict decubiti and DVT precautions, care of the urinary catheter and monitoring for shortness of breath, E2 stated that she did not remember anything being put in place for these orders. E2 also said that there is no documentation that would show that any of the physician's orders had been put in place other than the medications.

During interview with E3, (Registered Nurse Consultant) on 07-31-08 at 4:00 p.m., when asked what has been put in place to monitor R5 for decubiti, deep vein thrombosis precautions, respiratory status and daily weights, E3 replied, "I don't know anything about that so I guess none."

E3 informed surveyor that the facility monitored R5's intake and output while R5 had a urinary catheter. E3 continued to say that she did not monitor to ensure that intake and output was adequate. E3 also stated that she did not do any type of catheter care following R5's release from the hospital on 05-10-08 until 05-13-08 when the catheter was removed. (4 days).

During interview with E2 on 07-30-08 at 3:30 p.m., E2 stated that the urinary catheter care would have been the responsibility of E3 (Registered Nurse Consultant). E2 also said that there have been no daily weights for R5 because the facility has no way to weigh her. E2 continued that there is no documentation that R5 is non-weight bearing on her left leg or that edema and circulation are being monitored.

Per interview with E1 (Administrator) on 07-18-08 at 9:30 a.m., E1 stated that there was no written health plan implemented upon R5's return to the facility on 05-10-08 regarding non-weight bearing, elevation of the extremity, assessment of circulatory and respiratory status, daily weights, decubiti and DVT precautions and catheter care.

Per review of the direct support person's notes dated 05-12-08 and signed by E2, "Staff noted slight swelling and bruising to residents' left hand...." Documentation continues to say that R5 was taken to the orthopedic surgeon's office and an X-ray was taken. The X-ray determined that R5 had a fracture of her left hand. A splint was applied.

Upon review of the X-ray report dated 05-12-08, "Fractures involving fourth and fifth metacarpals. Mild dorsal bowing across the fourth metacarpal fracture."

According to the direct support person's notes dated 05-15-08, R5 was taken to the orthopedic surgeon and orders were received for Haldol 2 milligrams three times a day

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and Ativan 0.5 milligrams twice a day as needed. Documentation is signed by E2 (House Manager).

There is no evidence of nurse's notes or a health plan or recommendations for medical care to direct care staff following the diagnosed fractured hand and 05-15-08 orthopedist visit.

Upon review of documentation in the direct support person's notes from 05-15-08 through 05-21-08, surveyor noted an increase in R5's inappropriate behaviors. Documentation states:

05-15-08 - 8:00 p.m. - "...Verbally and physically aggressive towards staff. Hitting, kicking and screaming...". Documentation is signed by E5 (Direct Support Person).

05-15-08 - 1:00 a.m. - "...Physically and verbally abusive toward staff, throwing things and trying to take off hand brace and wrap on leg. Starting trying to disrobe, crying one minute, screaming the next. Staff tried to put her to bed (times) 3. She was up again after about 20 minutes." Pulse is documented as 110 at this time. Documentation is signed by E5

05-16-08 - 3:10 a.m. - "...(R5) was found sitting undressed in hall on women's end by the bathroom. Was assisted by staff to wheel chair and dressed. Was then brought into TV area where R5 was very agitated. She would not comply with staff. Was both physically and verbally abusive with staff. Was hitting, kicking, and screaming. Very agitated...." Vital signs were taken and R5's pulse was 105. "(R5) still very agitated throwing, hitting, screaming. Is non-compliant with all requests from staff. Res will not sit still keeps trying to get up. Staff keeps trying to re-direct resident. (R5) still combative at this time, taking off arm brace, Hitting staff...." Documentation is signed by E4 (Direct Support Person).

05-16-08 - 8:00 p.m. - "...Verbally and physically abusive towards staff. Hitting, screaming and kicking...." "...Complains of pain in hand and leg." Documentation is signed by E5.

05-17-08 - 4:30 a.m. - "Resident awake and still being verbally and physically abuse, crying, kicking, hitting, taking leg cast apart pulling out the cotton. Has removed hand cast several times is very tired and agitated wanting to take off casts...." Documentation is signed by E4 (Direct Support Person).

05-17-08 - 9:30 a.m. - "...She is very physically and verbally abusive. She has been hitting, kicking, yelling, screaming, pulling and taking off casts. She is constantly yelling she is in pain and everything hurts. Vitals are as follows B/P 144/82 P-106 T-97.2 R-22." Documentation is signed by E6 (Direct Support Person).

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05-17-08 - 6:00 p.m. - "...Res. hoarse from screaming. No complaints or discomfort noted at this time." Documentation is signed by E5.

05-18-08 - 5:30 a.m. - "...Res. seem to be in a better mood not so much hollering at this time..." Documentation is signed by E4.

05-19-08 - 8:00 a.m. - "...Seems very agitated..." Documentation is signed by E6.

05-20-08 - 2:15 a.m. - "Res. went to bed around 9 p.m.. Res. back up 1 a.m. yelling and screaming. She don't like anybody anymore and her leg hurt..." Pulse is documented as being 107. Documentation is signed by E7. (Direct Support Person).

05-21-08 - 10:30 p.m. - "Res. went to bed around 9 p.m. Staff heard res up in her room around 10 p.m. Staff went to check on res. Res was up walking in her room staff assisted res back to bed. Res was a little agitated. Keep saying don't like these kids anymore and she wanted everything off. Res had her brace off her hand and had it under her bed..." Documentation is signed by E7.

05-21-08 - 12:00 a.m. - "Res up at this time seems agitated. Res has been yelling throughout night and keeps taking brace off arm..." "... Came back to check on res. res was sitting on her bedroom floor going through her care basket under her bed. Staff assisted res. back to bed and put brace back on res. arm. Res is still yelling off and on it is 2:45 a.m." Documentation is signed by E7.

There is no evidence that the nurse or physician was contacted in regards to R5's increased pulse, increased agitation, behavior and complaints of pain following the 05-15-08 medication increases.

According to R5's Medication Administration Record dated 05-01-08 through 05-31-08, there is no evidence that R5 received medication for her complaints of pain as ordered by the physician.

During interview with Z6 on 07-30-08 at 3:55 p.m., Z6 stated that on 05-15-08 Z7 (his physician's assistant) had been contacted regarding R5's increased agitation and behavior. Z6 said that Z7 ordered ativan 0.5 milligrams to be given at bedtime and haloperidol 2 milligrams to be given 3 times a day. Z6 continued to say that neither he nor Z7 had been notified when the haloperidol and ativan failed to diminish R5's agitation and aggressive behaviors.

05-21-08 - 1:10 p.m. - Direct care notes state that R5 was taken to a follow-up appointment with Z6 (Medical Director) and orders were obtained to decrease the Oxycontin to 10 milligrams every morning and increase the Ativan to 1.0 milligram at bedtime. Documentation is signed by E2.

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R5's direct support person's notes dated 05-21-08 through 06-30-08 have no documentation to indicate that R5 displayed agitation, crying, verbal or physical abuse or complaints of pain after the Ativan was increased to 1.0 milligrams and the Oxycontin was decreased.

There are no nurses notes related to an assessment of R5's hand and ankle with recommendations.

Review of R5's direct support person's notes dated 06-18-08 at 2:30 p.m., states that R5 went to the orthopedic surgeon for a follow-up visit. The cast was removed and X-rays were taken of the left foot and left hand. "Dr. stated that left hand was healed and no longer needed to wear hand splint. However, Dr. stated that left ankle was not healed and 1 of the screws is slowly backing out. Dr. stated that res. would have to go back in and have another surgery on left ankle replacing screws with longer ones...." Documentation is signed by E2.

Direct support person's notes dated 06-24-08 at 1:40 p.m. state that R5 was taken to her medical doctor for clearance to have repeat surgery on her left leg on 06-30-08. Medical clearance was given for surgery and orders received for Duragesic 25 milligram patch every third day and Oxycontin 10 milligrams in the morning. Documentation is signed by E2.

There is no evidence that the nurse was contacted following the plan to surgically repair R5's fracture.

Direct support person's notes dated 06-26-08 at 12:30 a.m. state, "Staff heard noise from res room staff went to check and res was on floor in room on her buttocks and res knocked TV off her night stand...." Documentation is signed by E7.

The facility's incident and accident report dated 06-26-08 was reviewed. It states, "Fall." "Resident had gotten up to walk on her own." Documentation continues to say, "Staff observed resident sitting in floor on her buttocks and res. TV was on the floor...." Documentation is signed by E7.

There is no evidence of nursing assessment and recommendations for care. No evidence is shown that R5's supervision level was reviewed.

Per review of the direct support person's note dated 06-30-08 at 7:30 p.m., it states that R5 was taken to the local hospital for outpatient surgery to her left leg. Documentation is signed by E8 (Direct Support Person).

Per review of R5's hospital operative report dated 06-30-08, documentation states that R5 had a revision open reduction internal fixation of left medial malleolus fracture. The

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indication for the surgery is described as, "...There was evidence of progressive loosening of 1 of 2 medial malleolar screws and increasing fracture gap seen at the medial malleolus consistent with motion of the fracture and loss of fixation...."

Documentation within the direct support person's notes states that R5 was returned to the facility 06-30-08 at 7:30 p.m. The note also states that R5 was prescribed Vicodin 5/500 milligrams #30 as needed for pain. Documentation is signed by E8.

There are no nurses' notes following R5's return to the facility until 07-02-08. (2 days later).

Upon review of the Registered Nurse consultant notes dated 07-02-08 (no time documented) it states, "Short leg cast intact to left leg. Toes are warm to touch. Able to move toes on command. Staff is maintaining non-weight bearing to left leg." Documentation is signed by E3.

There is no health plan or recommendation for R5's care within E3's nurses notes.

Within the direct support person's notes dated 07-03-08 at 8:00 a.m. - Documentation states that R5 is, "Very agitated, yelling, crying. When asked what was wrong she just cried." No documentation is available to indicate that R5 was assessed or given pain medication as ordered. Documentation is signed by E6 (Direct Support Person).

There is no evidence that E3 was contacted for direction.

Direct support person's notes dated 07-05-08 at 7:00 a.m. state, "...Very agitated, yelling and screaming...." No documentation is written to show an assessment of R5's surgery site and circulatory status of extremities was completed. Documentation is signed by E6.

Per review of R5's Medication Administration Record dated 06-01-08 through 06-30-08 and 07-01-08 through 07-31-08, there is no documentation to indicate that the physician's order for Vicodin 5/500 milligrams as needed for pain had been administered on 07-03-08 or 07-05-08.

There is no evidence of nurse notification for direction and no evidence of nurse review with recommendations to staff for care.

Per interview with E2 on 07-25-08 at 1:30 p.m., E2 stated that the facility did not administer the physician's order for Vicodin 5/500 milligrams for R5 because she was already on Onycontin and a Duragesic patch. E2 continued to say that the physician was not contacted for clarification of the order as to whether he wanted Vicodin to be given in conjunction with the other medications or not.

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There is no evidence of nurse contact regarding medication.

Upon entrance to the facility on 07-17-08 at approximately 9:00 a.m., surveyor observed R5 sitting on the sofa in the living room. No staff was in the room with R5. R5 had her feet elevated on a footstool and a cast was on her left lower leg. The cast extended from below the knee to her toes.

During observations on 07-17-08 at 9:20 a.m., E2 (House Manager) took R5 into the dining room in a wheelchair. The wheelchair had no leg rests and both of R5's legs were dangling, not touching the floor

When interviewed on 07-17-08 at 9:25 a.m., regarding R5's wheelchair not having leg rests to elevate her legs; E2 stated that the facility does not have a wheelchair with leg rests. E2 said the wheelchair is only used for transfer and to take R5 to workshop. E2 said that when R5 arrives at workshop, she is placed in a recliner with her feet elevated.

Per observations on 07-17-08 at 11:10 a.m., R5 was in the seniors' room at the local workshop. R5 was sitting in a straight chair with her feet on the floor. R5's toes on her left foot were swollen, dark purplish color and cool to touch.

During interview with Z1 on 07-17-08 at 11:35 a.m., when asked about R5 not sitting in a recliner with her feet elevated, Z1 said, "That's where she always sits - that's her chair." Z1 stated that R5's feet were not elevated.

When interviewed on 07-17-08 at 11:40 a.m., regarding R5 not having her feet elevated, Z2 stated that R5 sits in the straight chair in the morning and in the afternoons a recliner is brought into the room for her to sit with her feet elevated.

Per interview with Z3 on 07-17-08 at 11:45 a.m., Z3 stated that R5 should have her feet elevated at all times. Z3 continued to say, "Her (R5) feet and lower legs have been having some edema lately."

During interview with E1 (Administrator) on 07-17-08 at 4:50 p.m., E1 stated that R5's left leg should be elevated at all times, whether at home or at workshop. E1 also stated that the facility does not have a wheelchair with leg rests for R5 to elevate her legs while transporting to workshop and return.

The facility failed to provide adequate adaptive equipment for R5 by not providing her with a wheelchair with leg rests to elevate her fractured left ankle.

Upon interview with E3 (Registered Nurse Consultant) on 07-18-08 at 4:15 p.m., when asked if R5's leg should be elevated at workshop, E3 replied, "I don't know what goes on at day training, I don't go there. When asked if there was a nursing care plan in place to

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address R5's needs in relation to her fractured left ankle, E3 stated that there was no formal written plan and that she did not understand why the facility had not written one. When asked what precautions should be taken with R5's fractured ankle, such as elevating the leg, watching for edema, color and temperature of her toes, extreme pain, no weight bearing, etc., E3 said, "Whatever the doctor ordered, I don't think I was even there when she came back." During same interview, when asked if there is a nursing assessment completed on a resident when they are returned to the facility after a hospitalization, E3 said, "If I'm there, I do - but I'm not always there."

E2 (House Manager) was interviewed on 07-18-08 at 1:05 p.m. E2 stated that either she or a direct care staff take the residents to their doctor's appointments. E2 said that after the appointment, the staff that who took the resident to the doctor's appointment document what the physician says during the exam in the direct support person's notes. E2 continued, there are no written physician's notes given to them. E2 continued to say that the nurse does not review direct care staff's notes regarding the physician's statements after an appointment, surgery or hospitalization.

E2 also stated that the facility does not receive physician's orders when a resident has a doctor's appointment, returns to the facility after a hospitalization or has outpatient surgery.

Per interview with E1 (Administrator) 07-18-08 at 10:30 a.m., when asked if the nurse receives direct information from the physician after an appointment, E1 said, "We've never done that, but it makes sense." E1 stated that the facility cannot ensure that the physician's statements to staff during a resident's appointment are implemented because they do not get any physician's notes.

Per same interview with E1, when asked what the facility has put in place to prevent R5 from falling again, E1 stated that there is no written plan to decrease the instances of R5's possible falls. E1 said, "She (R5) was on pretty heavy pain med. - We tried to back her off walking." E1 continued to say that she showed the staff how R5 was to be non - weight bearing and how to elevate her feet. When surveyor informed E1 that R5 had 4 documented fall since 04-30-08, E1 said that R5, "Has a history of unsteady gait."

The Registered Nurse Consultant notes dated 07-02-08 state, "Short leg cast intact to left leg. Toes are warm to touch. Able to move toes on command. Staff is maintaining non-weight bearing to left leg. No assessment is noted regarding R5's fractured left hand or urinary function.

Per review of R5's Individual Program Plan (IPP) dated 11-14-07, there have been no revisions to update R5's increased health and medical needs as based on her recent falls resulting in fractures to her ankle and hand.

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There are no updated nursing recommendations for R5.

During interview with E1 on 07-18-08 at 1:05 p.m., E1 confirmed that R5's IPP had not been revised to address R5's recent falls, decreased mobility levels and increased need for health monitoring. E1 also stated that R5's IPP did not address the type of assistance needed or supervision necessary for R5's unsteady gait.

2. Per review of R1's Physician's Order Sheet, dated 07-01-08 through 07-31-08, R1 is a 59 year old male who functions at a Mild level of mental retardation. Other diagnoses include: Asthma, Glaucoma, Aggressive Behavior, Inguinal Hernia, Seizure Disorder, Hypertension, Peripheral Ulcer Disease, Hyperlipidemia, Hyponatremia, Cerebral Vascular Accident with left Hemiparesis and Prostate Cancer.

Upon review of R1's ICAP dated 08-15-07, R1's overall age equivalency is 10 years and 2 months.

During review of R1's direct support person's notes, on 04-24-08 at 3:30 p.m., "This writer went down to res. room. Staff found res laying on res (resident's) left side on the floor. Res appeared to be having difficulty breathing. This staff attempted to assist res into a seated position. Res was unable to help hold himself up. Staff asked (E8) (direct support person) to go get the equipment to take res vitals and breathing machine. B/P at this time was 186/82 was unable to obtain pulse due to res was shaking. Staff (E2 and E8) assisted res up to bed and began breathing treatment. 911 were called at this time. Res was taken by ambulance to (local hospital) ER for evaluation. Documentation is signed by E2. (House Manager).

Further documentation in R1's direct support person's notes dated 04-24-08 (no time documented) states, "This writer arrived at (local hospital) ER shortly after res was transported by ambulance to ER. Physicians ordered CT scan and EKG. CT scan showed res had a stroke unable to know extent of damage at this time. Res admitted to ICU for further evaluation..." No signature is available as to who documented this entry.

Per review of R1's hospital report dated 04-27-08, a modified barium swallow was completed on 04-27-08 while R1 was in the local hospital. Documentation states that R1 has a diagnosis of dysphagia. R1 was placed on a pureed diet with honey consistency liquids.

Documentation states that on 04-29-08 at 11:30 a.m., R1 was returned to the facility from the local hospital.

E3 (Registered Nurse Consultant) notes dated 04-29-08 states "Hand grip equal. Smile equal. Drooling secretions after coughing spasm. B/P 90/60, P 120, R 28. Res.

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(complained of) feeling fatigued.

There is no evidence that the nurse reviewed R1's hospital records, evaluated his needs and developed a plan of care.

No documentation is in the nurse's notes to identify what R1's vital signs should be before contacting the nurse or physician. Also no documentation is available as to what staff is to do about R1's coughing spasm, drooling or complaints of feeling fatigue.

Per review of R1's Occupational Therapy Evaluation (O.T.) dated 05-08-08, documentation states, "...59 y.o. (right) hand dominant male s/p stroke (with) left hemiparesis presenting with impaired fine motor control, swallowing difficulties...".

The O.T. evaluation does not have recommendations for care including the pureed diet and honey thickened liquids. It also does not recommend care and programming for R1's impaired fine motor control.

There is no evidence in R1's IPP that his diet was updated based on the 04-27-08 barium swallow following his 04-24-08 stroke.

There is no evidence of programmatic changes based on R1's changed physical health status.

The next entry in R1's Nurse Consultant notes is dated 07-09-08, the nurse documents, "Completed quarterly (nursing assessment), aims and braden ulcer potential. Res has lost 7.4 (pounds) in 3 mos. Con't (continue) on mechanical soft diet. Staff instructed to check weight weekly. Refer for medical evaluation if weight does not increase." Documentation is signed by E3 (Registered Nurse Consultant).

No documentation is noted as to what staff is to do to maintain R1's weight. There is no evidence of set parameters for the nurse or physician notification.

There is no documentation within R1's nurses' notes as following up to R1's complaints of feeling fatigued, drooling and having coughing spasms.

During review of R1's direct support person's notes dated 04-30-08 at 5:00 a.m., it states that R1's B/P is 170/96 and his pulse is 94. Documentation is signed by E6.

R1's direct support person's notes continue on 05-04-08 at 8:00 p.m., R1's blood pressure is 150/96. Documentation is signed by E7.

The facility is unable to provide evidence that either the nurse of physician was contacted regarding R1's increased blood pressure on 05-01-08 and 05-04-08.

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3. The Physician's Orders sheet dated 07/01/2008 through 07/31/2008 states that R3 is a 61 year old female who functions at a moderate level of mental retardation and has diagnosis which includes Cerebral Palsy.

On 07/17/08, the facility provided the surveyors with a list which identified that R3 had a decubitus ulcer on the inside crease of her buttocks from 05/30/08 to 07/08.

During interview with E2 (House Manager) on 07/18/008 at 1:00 p.m., E2 stated that R3 had acquired the decubitus ulcer at the facility.

R3 was observed during the survey dates requiring standby assistance when walking with her walker. R3 also required the use of a wheelchair for mobility during transport to day training services.

According to the Nurse's Notes dated 05/28/08 at 4:15 P.M. staff noted a small open area on the inside crease of R3's left buttock.

The RN (Registered Nurse) Consultant sheet dated 05/28/08 states, "20 mm (millimeter) full thickness open area noted on inside of right buttock. Referred for medical evaluation."

There is no evidence in the 05/28/08 note that E3 staged the open area. There is also no evidence that E3 made recommendations to direct care staff for repositioning and/or made a dietary referral to ensure dietary protein intake.

R3's Nurse's Notes of 05/29/08 identifies that R3 was seen by a physician assistant on this date for her open area. Orders were received for Duricef 500 mg tablet Bid (twice daily) for 10 days, Duoderm 4x4 Hydroactive daily, Sodium Chloride Solution 0.9% (to irrigate open area) and for Tegaderm Transparent Dressing. From 05/29/08 to 06/18/08, no nursing documentation is noted regarding the status of R3's skin integrity. On 06/19/08, R3 was seen by her physician. The 06/19/08 Nurse's Note identifies that R3 was seen by the physician and that her (R3's) left crease of her buttock was healing. It was also noted that R3 had an "area thinning" on the right side of her buttock. Orders were received for a donut cushion, continued treatment for R3's open area on her left buttock and that Duoderm and Tegaderm be started for the thinning area on her right buttock.

After the 06/19/08 entry, no further nursing entries are noted regarding the status of R3's areas on her left and right buttock until 07/16/08 when nursing (E3) documented that the right area of R3's buttock had healed.

R3's Braden Scale for Predicting Pressure Score Risk dated 03/12/08 identifies that she scored a total score of 19. This assessment notes that individuals with a score of 18 or

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above are "At Risk" and are not classified as a moderate or as a high risk for developing pressure sores. R3 was not reassessed after developing an open area on 05/28/08, nor was a prevention plan developed for maintaining skin integrity after she developed an open area on 05/28/08 requiring saline irrigation, Duoderm and Tegaderm.

R3 was observed at the day training site on 07/17/08 from 11:00 - 12:00 P.M.. R3 was observed sitting in a wheelchair and was not observed repositioned during observation. At 4:30 P.M. (on 07/17/08 at the facility) R3 stated, "No" when asked if she transfers from her wheelchair while at day training.

E1 (Administrator) was interviewed on 07/18/08 at 4:25 P.M. and stated that the facility uses the Braden Scale for Predicting Pressure Score Risk as R3's care plan for her open area.

R3's Braden Scale for Predicting Pressure Score Risk assessment identifies a total score of 19 as based on the following areas:

Sensory Perception - No Impairment... Score 4
Moisture - Occasionally moist... Score 3
Activity - Walks occasionally... Score 3
Mobility - Slightly limited Score 3
Nutrition - Excellent Score 4
Friction and Shear- Potential Problem... Score 2

The second page of this assessment states that with a score of 19, the following actions should be taken, "Frequent turning, maximal remobilization, protect heels, manage moisture, nutrition and friction shear pressure reduction support surface if bed or chair bound. Manage moisture, use commercial moisture barrier, use absorbant pads or diapers that wick and hold moisture, address cause if possible, offer bed pan urinal and glass of water in conjunction with turning schedules."

There is no evidence that the Braden Scale assessment recommendations had been incorporated in R3's Individual Program Plan (IPP) dated 02-13-08 with specific objectives and techniques to prevent R3's skin breakdown.

Further review of this assessment does not address how the facility will document the decubitus ulcer(s), staging of the ulcer/open area, presence of drainage and or the condition of other skin surfaces. This assessment also does not reflect physician's orders specific to the individual for medication(s) and/or treatments and or changes in nutritional/dietary orders.

E2 (House Manager) was interviewed on 07/18/08 at 1:00 P.M. E2 stated, "Staff documented R3's open area which was found on 05/28/08. R3's open area to the left

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buttock was healed on 07/14/08. During that period (05/28/08 - 07/14/08), E3 (RN) was out of town so that's probably why there is no documentation from the nurse. No individualized skin care plan was developed for R3 to address her open areas. Workshop was not notified of the open area on R3's buttock(s). The last Braden Scale for Predicting Pressure Score Risk assessment was done on 03/12/08 by the nurse (E3). No, this assessment has not been updated, nor is there a more current assessment on file since 03/12/08."

4. The Physician's Orders dated 07/01/08 through 07/31/2008 identify that R3 is a 61 year old female who functions at a moderate level of mental retardation and has diagnosis of Cerebral Palsy, Osteoporosis and Arthritis.

R3 was observed at the day training site on 07/17/08 from 11:00 - 12:00 P.M. R3 was observed sitting in a wheelchair and was not observed repositioned during this observation. R3 was observed later at the facility using a wheeled walker for ambulation with staff assisting.

On 07/17/08 at 5:55 P.M. while talking with R3, she informed the surveyor that she can transfer herself out of her bed and out of her wheelchair without staff assisting. E2 (House Manager) was present in the dining room during this time and stated, "Yes, she (R3) can, but she is to have staff assistance when transferring."

During Task II of the survey on 07/17/08, the following incident reports were noted for R3:

03/03/08 unobserved fall while walking in the dining room;

04/02/08 observed fall in the dining area, hitting the left side of her head on a chair;

06/21/08 unobserved fall in the bathroom;

06/23/08 observed fall in the dining room;

06/25/08 unobserved fall out of the bed;

In reviewing R3's Nurse's Notes for the 04/02/08 fall, no documentation was noted until 04/06/08. This documentation states, "04/06/08 ...res (R3) has been complaining of her right leg bothering her..." The next day, R3 continued complaining of pain in her right upper thigh area and was having difficulty ambulating. R3 was seen at an after hours clinic. Orders were received to elevate her leg, apply ice and to take Ibuprofen 600 mg, three times daily.

R3's Nurse's Notes further states,

CONT.

06/21/08 "... Peer came and got this staff, stating that res, had fallen. Upon arrival into women's bathroom staff found res. sitting on floor... Staff asked what had happened. Res. stated that she had tripped over her walker..."

06/23/08 "Res was walking into the dining area and lost her balance causing her to fall. Res landed on her left side then rolling over on to her back..."

06/24/08 "... She (R3) had to be assisted dressing, stating that she was hurting and couldn't do it. Res. was walking to the dining room and mid-way she stated she was going to fall because her leg was hurting. When being assisted on the bus she wouldn't put any pressure on leg. She went on to workshop..."

06/25/08 " Res fell in her room slipped off bed. No signs of injury at this time..."

06/26/08 "Res complain continuously about pain in her leg. When assisted on workshop bus, she wouldn't bare (bear) any pressure on the leg."

No further nursing entries were noted in R3's Nurse's Notes regarding the pain in her legs or difficulty in bearing weight or that nursing was contacted when R3 fell.

R3's Fall Risk Assessment dated 08/01/07 identifies that she has a total score of 12 which places her at a moderate risk for falls. Under the section marked "History of falls (Past 3 months) it is noted that R3 has had 1-2 falls in the past three months giving her a score of 2. There is no documentation to indicate that she was reassessed by nursing for falls after 08/01/07. In reviewing R3's four documented falls during April through June of 2008, if R4's Fall Risk Assessment had been updated, these (four) falls would have increased her fall history score from a 2 to a 4 (3 or more falls in the past 3 months - Score 4), placing her at a "high risk" for falls.

The Nursing Quarterly Assessment dated 07/16/08 identifies three falls (06/21, 06/23 and 06/25/08) for June of 2008, but does not show that any action was taken. This assessment does not reflect R3's April fall, when she fell and hit her head on the dining room chair.

There is no evidence in nurse's notes that E3 did a complete body assessment of R3, completed an accurate evaluation of patterns and trends, developed a plan of care and made recommendations to direct care staff related to R3's multiple falls.

E1 was interviewed on 07/17/08 at 3:30 P.M. and stated, "R4's last fall risk assessment was done on 08/01/07. There is none more current. No plan of care has been developed to address R3's falls..."

(A)