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HERITAGE HEALTH-JACKSONVILLE	873 GROVE STREET JACKSONVILLE, IL 62650

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F 000	INITIAL COMMENTS Annual Recertification and Licensure Complaint Investigation 1142786 (IL 54445) - F157, F309, F323 Validation Survey for Subpart U: Alzheimer Unit - Barton Stone is in substantial compliance with Subpart U: 77 Illinois Administrative Code 300.7000	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157		10/16/11

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

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F 157	Continued From page 1 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interviews, observations, and record review, the facility failed to immediately notify the physician or family member of a condition change for 2 of 26 residents (R25 and R2) reviewed for notifying family and/or physician in a sample of 26. Findings include: 1. Record review of R2's ULCER Care Plan - Treatment Plan of 8-15-11 documents a pressure sore on R2's left heel with an "X" next to stage 1 "Non-blanchable erythema, discolor dark skin or warmth/edema/induration. Skin intact. Size: length; 3 width: 2.5 Drainage: none" An undated note under Initial Entry Note: had documentation, "DTI (deep tissue injury) to L (left heel, waffles to feet, et (and) floated, area dark brown, boggy et intact. Dr (Doctor) updated for skin prep order." On 9-16-11 at 11AM, E13 (Treatment Nurse) stated she had written the note concerning DTI on 8-18-11. (R2's Treatment Administration Record (TAR) and Physician Order Sheet (POS) show the facility did not get a treatment order until 8-22-11 when order was obtained for skin prep and cover with Allevyn heel dressing and Kling. Record review of R2's ULCER Care Plan - Treatment Plan from 8-15-11 through 9-15-11 show a decline in the pressure sore with no	F 157		

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F 157	Continued From page 2 documentation marked under section "Dr. Notif" (Doctor Notification) until 9-15-11. During interview with E19, LPN, on 9-15-11 at 3:45PM, E19 stated she does treatments to R2's heel. E19 stated when she first saw R2's left heel it was a blister. E19 states its now real beefy red with brown dried edges. She said she changes the dressing every night when she works. Last week the blister broke and they were still using skin prep (Sureprep) to the heel. The heel didn't seem to be improving over the weekend. E19 stated she felt the skin prep was not working and the pressure sore was getting worse. E19 felt the treatment needed to be changed and on Sunday, September 11, 2011, she let the night Nurse know so the Physician could be notified. Nurses Notes of 9-14-11 at 2325 document R2's Physician was faxed an update with regards to treatment to left heel - no improvement. A Fax provided by E21, Corporate Nurse, showed a Fax Communication form dated 9-15-11 at 0730 sent to R2's Physician documenting R2 "has current order for skin prep L heel. Area now open can we DC (discontinue) current order et change to cleanse dly (daily with normal saline or wound wash, apply silvasorb gel to open area Cover with foam pad et wrap with kerlix?" The Fax was signed with OK and sent back to the facility on 9-15-11 at 1431. 2. R25's nurses notes written on 8/28/11 at 11:53pm documents that "CNA (Certified Nurses Aide) reports repositioning in bed - pulling resident up in bed c (with) his assist - grabbed right upper arm to pull up in bed - received skin tear" measuring 4cm x 2cm in half moon shape. The notes document that the physician was notified per fax but there is no evidence that the	F 157		

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F 157	Continued From page 3 family member, power of attorney (POA) was notified of the injury. On 9/13/11 at 2:30pm, r25's family member and Power of Attorney (POA), Z2, stated she was unaware of the skin tear occurring until after he expired on 8/31/11. Z2 stated she was unaware that he had injuries/wounds on his feet. Record review shows that R25 was seeing a wound specialist for his right foot second toe, however, pictures also show R25's left great toe having steri strips on it as well. Again, there is no evidence present in the clinical record that shows R25's POA was informed on this injury/wound. As of 3pm on 9/16/11, E2 Director of Nurses, provided no evidence of notification to R25's family on either the foot and/or the upper arm skin tear.	F 157		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews, observations and record review, the facility failed to adequately assess/monitor and treat excoriation and bruising for 2 of 9 residents reviewed for skin issues in a sample of 26. Findings include:	F 309		10/16/11

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1. The Admission Sheet identifies R25 as being an male age 88 admitted to the facility on 7/3/11 with diagnosis of Renal Failure, Non-compliant Dialysis, Diabetes Mellitus. The Physician Order Sheet (POS) for August 2011 indicates R25 received Plavix 75 every day and Aspirin EC 81mg daily along with other medications.

The care plan dated 8/1/11 identifies R25 to have skin issues including bruising & delayed healing time possible secondary to dx (diagnosis) of chronic Lymphoid leukemia, chronic kidney disease with dialysis, cardiac problems,diabetes, and anticoagulant & diuretic med use.

The care plan identifies R25 to have a bruise on 8/22/11 left upper axilla. Interventions dated 8/23/11 document staff are to "monitor bruise to L (left) axillary area until healed." According to the nurses notes dated 8/22/11 written at 4:35pm, R25 had "repots of hematuria x (times) 1 during shower with large bruise on L side. Bruise assessed 8in x 5.5in noted under l armpit et (and) exceeding down et back toward back. Tender under armpit/breast area to touch. MD called et made aware. No new orders received. POA (Power of attorney) aware."

On 8/23/11, R25's physician called and placed the Plavix on hold due to the bruising. The nurses notes fail to reflect any further information including continued monitoring/assessments on either the hematuria and/or the extensive bruising and the effects of holding the Plavix.

According to the nurses notes R25 expired on 8/31/11. Pictures provided by Z4 (Funeral Home Director) show extensive bruising beyond the 8in by 5.5 inch initially identified on 8/22/11. The picture showed dark purple blue bruising present from 1 inch inside R25's left nipple extending

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F 309	Continued From page 5 down to his waist, under his left axilla towards his back with varying shades of bruising ranging from purple/blue/red to yellow/green. Z4 confirmed these photos were of R25. Evidence of monitoring/assessing this bruising was requested from E2, Director of Nursing on 9/16/11 with none being provided. 2. R1's Admission Nursing Assessment, dated 9-7-11, documented R1 was admitted from a local hospital with diagnosis, in part, of Alzheimer. It was also noted R1 was an extensive assistance with bed mobility, transfers and locomotion and deep rash to her entire buttock. R1's Wound Care Plan - Treatment Plan, dated 9-7-11, documented "excoriation/rash/dermatitis" of R1's entire buttock. R1's Wound Care Plan did not document measurements or specific areas of excoriation/rash/dermatitis. On 9-14-11 at 10:30a.m., E6, Certified Nursing Assistant (CNA) and E7, (CNA), were observed providing R1 with incontinent care. R1's buttock, coccyx and lower middle back were observed with well defined, deep red areas of irregular sizes, from 1cm x 1cm round to 4cm x 3cm oblong. On 9-15-11 at 8:50a.m., E9, Licensed Practical Nurse (LPN), was observed providing a treatment change to R1's right heel. R1 repeatedly complained of buttock pain during the observation and R1's buttock, coccyx and lower middle back were observed with well defined, deep red areas of irregular sizes, from 1cm x 1cm to 4cm x 3cm oblong. R1's chart and Wound Care Plan - Treatment Plan did not document assessment, monitoring or measurements of R1's buttock, coccyx and lower middle back until R1's 9-14-11 Wound Care Plan	F 309		

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F 309	Continued From page 6 - Treatment Plan. It was noted, in part, "noted with 5.5cm x 2.0cm excor (excoriation) area to (L) (left) inner ischial, 1.0cm x 1.0cm area to coccyx, 6.0c m x 2.2cm area to (R) (right) ischial and scratches noted to (L) upper ischial area." Areas on R1's lower middle back were not documented. E8, Alzheimer Unit Manager, stated on 9-15-11, that measurements of R1's buttock, coccyx and lower middle back were not done until 9-14-11.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to consistently and accurately assess, monitor and implement new treatments for pressure sores to prevent decline for 3 of 5 residents (R2, R3 and R14) reviewed for pressure sores in a sample of 26. This failure resulted in R2 having a decline and increase in size in her pressure sore from purple non-blanchable area on her heel to an unstageable pressure sore with full thickness loss with drainage. This failure resulted in R3 developing an avoidable pressure sore on her	F 314		10/16/11

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right trochanter that facility did not identify, assess and treat until it was unstageable.

Findings include:

1. Record review of R2's Admission Sheet of 8-15-11 shows documentation that R2 was readmitted to the facility from the hospital with purple non-blanchable area on her left heel.

Record review of R2's ULCER Care Plan - Treatment Plan of 8-15-11 documents a pressure sore on R2's left heel with an "X" next to stage 1 "Non-blancheable erythema, discolor dark skin or warmth/edema/induration. Skin intact. Size: length; 3 width:2.5 Drainage: none" An undated note under Initial Entry Note: had documentation, "DTI (deep tissue injury) to L (left heel, waffles to feet, et (and) floated, area dark brown, boggy et intact. Dr (Doctor) updated for skin prep order." On 9-16-11 at 11AM, E13 (Treatment Nurse) stated she had written the note concerning DTI on 8-18-11. (R2's Treatment Administration Record (TAR) show the facility did not start treatment until 8-22-11 when order was obtained for skin prep and cover with Allevyn heel dressing and Kling. This was 7 days after a stage 1 was identified and 4 days after DTI was assessed.)

The next assessment of 8-25-11 on the ULCER - Treatment Plan, shows pressure sore measured 3.2 x 3.1 cm with <0.1 cm depth with scant Serosanguinous drainage and is red in color. A note is written with documentation: "Necrotic tissue off, 100% red dermis, 0 undermining, 0 tunneling cont (continue) current TX"

The next assessment of 9-1-11 documents pressure sore is 3 x 3 cm with superficial depth

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and no drainage and red in color. Note "100% red dermis heel protector in place cont current tx."

The next assessment of 9-8-11 shows documentation that the pressure sore is 3.2 x 3 cm unstageable 0.1 black. Note states to continue same treatment.

The next assessment of 9-15-11 shows documentation that pressure sore is 3 x 3 cm with <0.1 depth with scant serosanguinous drainage ane 0.8 x 0.5 red dermis and .4 x .6 black. Note documents Physician was notified on 9-15-11.

R2 was observed on 9-14-11 at 10:10AM to be in bed and had an Allevyn heel and Kirlex on her left heel. E14, Licensed Practical Nurse (LPN) removed the dressing from R2's heel. The Allevyn heel was stuck to the wound and there was dark brown drainage. The pressure sore was beefy red with edges that were black in some areas. The beefy red area was a full thickness wound. E14 cleansed the wound with wound cleanser and gauze and then put R2's heel down on the pillow at the foot of her bed. E14 then opened a Sureprep wipe and wiped around and over the pressure sore. E14 fanned R2's heel until Sureprep dried and then placed a gauze pad in the same soiled Allevyn heel and placed the dressing on R2's heel. E14 was asked if she was using the same dressing that she just took off and E14 confirmed she had used the same Allevyn heel. E14 then stated maybe she shouldn't and took the dressing off R2's heel, took out the gauze pad and confirmed the Allevyn was soiled with brown drainage. E14 then placed R2's ankle on the pillow and told her not to let the pillow touch her heel. E14 left the room to get supplies and when she came back, R2 had rearranged her foot and the pressure sore was touching the

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pillow. E14 put a new gauze pad into a new Allevyn heel, put the dressing on R2's heel and dressed with kling without re cleansing the pressure sore.

On 9-15-11 at 10:25AM, E13 stated R2's heel was red when first admitted and then identified as DTI. E13 confirmed R2 has not had a treatment change. E13 stated she had just today, sent information to the Doctor to see if they could change the treatment order. At 1:40PM, E13 stated the pressure sore was a full thickness skin loss with partial brown edges and had been like that for about a week.

According to the manufacturer's information for Sureprep, provided by the facility on 9-15-11, Sureprep is for management of healing wounds to provide an additional barrier to the delicate skin around a wound during the healing process. During an interview on 9-15-11 at 9:45AM, with Z3, Certified Wound Specialist/Nurse for Sureprep, Z3 stated the only time Sureprep is to be used is to protect intact skin. It should not be used on full thickness loss. It's contraindicated for full thickness loss wounds.

Record review of Nurses Notes from 8-15-11 through 9-14-11 shows no documentation that R2's Physician was contacted of decline in the pressure sore. Physician order sheets from 8-22-11 through 9-14-11 show there was no change in treatment order even though the pressure sore on the left heel showed a decline.

Nutrition Assessment of 8-24-11 shows R2 was admitted on 8-15-11 with a weight of 130 lbs and a DWR (desired weight range) of 97-138 lbs. The Assessment shows history of poor intake and estimated intake < 25%. Assessment documents general mechanical diet is adequate to meet nutritional needs, area on left heel DTI;

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poor intake with recommendation for supplement due to weight loss and open area. R2's TAR shows R2 weighed 118 lbs on 9-1-11 and 9-7-11 yet there in no Nutritional Assessment address the significant weight loss or the decline in pressure sore. The Facility was informed of concern on 9-14-11 and had the Dietitian assess on 9-15-11 with recommendation for increased nutritional supplement.

R2's laboratory test of 9-7-11 show total protein and albumin are within normal limits.

During interview with E19, LPN, on 9-15-11 at 3:45PM, E19 stated she does treatments to R2's heel. E19 stated when she first saw R2's left heel it was a blister. E19 states its now real beefy red with brown dried edges. She said she changes the dressing every night when she works. Last week the blister broke and they were still using skin prep (Sureprep) to the heel. The heel didn't seem to be improving over the weekend. E19 stated she felt the skin prep was not working and the pressure sore was getting worse. E19 felt the treatment needed to be changed and on Sunday, September 11, 2011, she let the night Nurse so the Physician could be notified.

Nurses Notes of 9-14-11 at 2325 document R2's Physician was faxed update with regards to treatment to left heel - no improvement. Fax provided by E21, Corporate Nurse, showed Fax Communication form dated 9-15-11 at 0730 sent to R2's Physician documenting R2 "has current order for skin prep L heel. Area now open can we DC (discontinue) current order et change to cleanse dly (daily with normal saline or wound wash, apply silvasorb gel to open area Cover with foam pad et wrap with kerlix?" Fax was signed with OK and sent back to the facility on 9-15-11 at 1431.

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F 314	Continued From page 11 2. According to Minimum Data Set (MDS) dated 8/29/11, R3 requires extensive assist of staff for transfers and bed mobility and is frequently incontinent of bladder. The Braden Scale dated 8/31/11 identifies R3 as a "moderate risk" for pressure ulcer development. Labs dated 4/13/11 indicate Albumin is 2.6 (normal 2.4 - 4.3) and Total Protein 5.7 (Normal 5.1 - 7.2) are both normal. The Registered Dietician identified a weight gain of 5 pounds on 8/18/11. The Physician's Order sheet (POS) for September 2011 indicates R3 receives Med Pass 120cc three times daily. The care plan dated 7/14/11 identifies R3 at risk for skin breakdown. The Pressure Ulcer weekly report identifies R3 as developing an in-house acquired ulcer on her right trochanter on 8/21/11. The nurses notes also reflect the pressure sore and indicates it measured 1.6cm x 1.4cm with a necrotic area in the center measuring 0.5cm x 0.2cm, stage III. There is no justification for the development of this ulcer and no explanation as to why the area was not identified prior to the development of the necrotic area. The "Weekly Ulcer Report" dated 9/1/11 reflects the initial ulcer on the right trochanter and an additional ulcer developing in the same area which measured 1.0cm x 0.2 staged at a II which began as a blister. On 9/16/11 at 10:30am, E2 Director of Nursing (DON) identified R3 as being on Hospice and the pressure ulcers being "unavoidable" offering documentation, Clinically unavoidable pressure sore guide tool", that lists R3 as having Hemiplegia and chronic urinary incontinence and having labs that indicate R3 may be at risk for malnutrition and/or dehydration/poor healing. The tool also includes interventions implemented at	F 314		

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the time the ulcer were identified but don't include any reference to her right side. Interview with E15, Certified Nurses Aide, said on 9/16/11 at 12:45pm, that R3 has declined in the past couple months and always insists on laying on her right side when in bed so she can face the wall.

R3 was observed to sit in her chair at bedside and/or in the dining room throughout the survey except for toileting.

The ULCER POLICY & PROCEDURE indicates all residents will be assessed upon admission, quarterly and as changes occur. The policy includes protocol for low, moderate and high risk residents. Moderate risk indicates "Daily skin checks are completed, as well as weekly skin checks by CNA (Certified Nurses Aide) on bath day using the "skin observation worksheet." The policy continues under HIGH RISK to document that "residents with existing ulcers will be scored at high risk automatically." There is no documentation that R3 was reassessed for risk following the development of the stage III pressure ulcer.

3. The Facility Care Plan with the target date of 10/28/11 documents that R14 has diagnoses that include; Diabetes Mellitis, Hypertension, Depressive Disorder, Senile Dementia and generalized pain. Review of the care plan problem area of skin, dated 8/30/11 documents a stage one pressure ulcer to the right heel and stage two pressure area to the left heel. Under the area of goals is documented "right heel discontinued on 9/7/11 and 9/8/11." Review of the current MDS dated 7/14/11 documents that R 14 requires extensive assistance with all activities of daily living, is non- ambulatory and uses a

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F 314	Continued From page 13 wheelchair. She is also assessed as being at risk for pressure ulcers and requires pressure relieving devices in bed and in the chair. Review of the Facility "Weekly Ulcer Report" for the week of 9/1/11 documents that R14 has a Stage one pressure ulcer to the right heel measuring 2.5 by 1.7 centimeters, and a stage two pressure ulcer to the left heel measuring 0.5 by 0.3. The Weekly Ulcer Report dated 9/8/11 documents that R14's Right heel wound is resolved and the left heel measures 2.1 by 2.5 centimeters. There is no documentation of any dressing to R 14's coccyx area. A skin check done with E20 Registered Nurse, on 9/14/11 at 4:30PM. Observed that Right heel has a darkened area, firm to the touch, and non-blanching. E20 stated, " there is still something there so we should be tracking that until it is gone." Skin check with E16 on 9/14 /11 at 4:00PM. R 14 was observed to have an occlusive dressing area applied to her coccyx. When the dressing was removed, the entire coccyx was reddened and towards the center were several open areas with skin peeling back in small sections. E 16 stated, "well I asked the wound care nurse about this dressing because we didn't have any for (R14), and she stated, hospice has been putting that on because of irritation due to incontinence. No we have not been tracking or measuring that area."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the	F 315		10/16/11

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F 315	Continued From page 14 resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure good catheter care for 1 of 2 residents, R2, reviewed for catheter care in the sample of 26. Findings include: 1. Record review of R2's September Physician Order Sheet documents R2 has a indwelling urinary catheter. R2's POS shows an order for Levaquin 250 mg daily on 9-7-11 for a UTI. R2 was observed on 9-14-11 at 10:10AM to be incontinent of bowel and had a urinary catheter. E22 and E23, CNA's were observed to do incontinent care but failed to cleanse R2's catheter tubing.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		10/16/11

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This REQUIREMENT is not met as evidenced by:
Based on interviews, observations and record review, the facility failed to ensure residents receive adequate supervision and proper assistance to prevent falls and skin tears for 6 residents R7, R17, R19, R21, R22 and R25 of 15 residents reviewed for falls and bruises/abrasions in the sample of 26. The failure resulted in R19 obtaining a left hip fracture.

Findings include:

1. The Minimum Data Set (MDS) dated 04/13/11 documents R19 as having short/long term memory deficits with moderate cognitive impairment and requires assist of one staff for mobility. The Fall Assessment dated 03/21/11 identifies R19 at a moderate risk for falls. The Care Plan dated 04/12/11 identifies R19 as needing assistance of one with a gaitbelt and wheeled walker with transfers, ambulation to/from bathroom and walking in corridor.

The Occurrence Report dated 04/10/11 at 8:55 AM, documented R19 was "observed sitting on floor in the resident's room." The report further documented cognitive level of "oriented x 2" and "no injuries noted." On 04/10/11 at 8:00 PM, additional information was documented as "skin tear 3.5 x 2.5 x 0" and a resident statement was given as "I was reaching for my coffee cup earlier today and there was stuff in the way and I must of hit my arm then." Treatment documented as "Steri strips applied." Interventions documented on the report as "Will look at room to arrange

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area for resident to put coffee and other items within easy reach. Will continue to monitor area until resolved. Will have maintenance look at room for any sharp edges to help prevent future skin tears."

Another Occurrence Report dated 04/22/11 at 7:31 PM, documented R19 was "observed on floor in dining room." The report further documented cognitive level of "oriented x 1" and "pain when ROM performed, resident complained of left hip/leg pain, outside services required." Documentation indicated that R19 was transported via ambulance to the hospital. Hospital documentation indicated that R19 sustained a Left Hip Femoral Neck Fracture and underwent Left Hip Hemiarthroplasty. Nurses Notes indicated that R19 was repeatedly walking without assist of staff and/or walker days and the evening approaching the fall on 04/22/11. On 04/28/11, R19 was readmitted to the Facility. On 04/28/11, the Care Plan indicated "personal alarm" was added as an intervention.

On 09/13/11 at 10:30 AM, E24, LPN, stated the Facility attributed the fracture to a fall on 04/22/11.

On 05/03/11 at 11:50 PM, an Occurrence Report documented that R19 was "observed on floor in resident's room, laying along side of bed on back." The report documented prevention measures at the time of fall "Alarm: None." R19's cognitive level was documented as "oriented x 1." The report documented "Immediate Actions Taken:...Alarm applied." There was no further changes made to the Care Plan at this time.

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F 323	Continued From page 17 On 05/12/11, the "Endurance/Functional Ability Assessment" documented R19 "transfers with extensive assist of 1-2 using gait belt and wheeled walker...Extensive assist for toileting, bed mobility, dressing and personal hygiene also..." On 08/20/11 at 12:30 AM, an Occurrence Report documented that R19 was "observed on floor on his back with his head near closet in resident's room." The prevention measures at the time of fall "Alarm: none." The report documented resident statement "I don't know for sure but I think that I lost my balance and fell. It made my bad hip start hurting again." Documentation indicated that R19 was transferred via ambulance to the hospital for treatment and returned later the same day. On 08/24/11, after many complaints of pain of the left hip/leg by R19, R19 was transferred to the hospital and admitted with the diagnoses of Anemia and Urinary Tract Infection. 2. Per the admissions face sheet R17 has current diagnoses which include; Cerebral Vascular Accident, Transient Ischemic Attack, Senile Dementia, Insomnia and Acute and Chronic Urinary Tract Infections. The most recent MDS dated 7/11/11 documents that R 17 is severely cognitively impaired, with both short and long term memory problems. The Facility Fall Assessment dated 7/10/11 documents that R 17 is at high risk for falls. The Plan of Care with the Target date of 10/25/11 under the problem area of Mobility deficits does not include any connection to R17's Urinary Tract Infections (UTI) or UTI symptoms that warrant interventions or the need to increase supervision for R17 during these times.	F 323		

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F 323	Continued From page 18 Facility Occurrence reports dated 10/12/10, 1/30/11, 3/8/11, 5/31/11 6/2/11, 6/25/11, 7/15/11, 8/28/11 and 8/30/11 document that R17 had repeated falls. The Facility Occurrence report dated 6/2/11 states, " Fell out of Broda Chair while at the nurses station, no witnesses." The intervention recommendation for this incident states, "Current Broda Chair to be replaced with drop seat wheelchair and self releasing seat belt." The 6/25/11 Occurrence Report states, "fell on floor next to Broda chair out in common area, no witnesses, head trauma noted...abrasion." No changes in care interventions were provided by the facility between the 6/2 fall and the 6/25 fall. The Facility occurrence report dated 8/28/11 documents R17 fell out of her bed on to the mat at the bedside. Facility Recommendations were to, "continue current safety measure and re-evaluate effectiveness." R 17 fell again on 8/30/11 from her bed to the mat on the floor. This fall per the report resulted in a head injury. No changes in care interventions had been made between the 8/28 and 8/30/11 fall. Facility follow up written by E3,RN, on 8-31-11, notes that R 17 "had an elevated temperature and increased restlessness with frequent attempts to toilet herself. Recommendations state, continue current safety measure which are effective when (R17) does not have a Urinary Tract infection." There are no interventions/recommendations given on the occurrence report or on the current care plan for increased supervision when R 17 states to display signs/symptoms of a Urinary Tract Infection. E17, LPN, stated during the facility tour on 9/13/11 at 10:30 AM that the bruise was a result of R17's most recent fall dated 8/30/11.	F 323		

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F 323	Continued From page 19 On 9/13/11 at 11:30AM, E3 stated "yes she got the bruise as a result of that fall, we know she has these falls when she gets a urinary tract infection. She gets more restless and agitated, and crawls out of bed or out of her chair." On 9/13/11 at 11:30am, R17 was observed in her Broda chair in the dining room at the table. R17's left side of her face was black/blue/purple extending from her hairline to her upper neck. 3. R25 nurses notes indicate he sustained a skin tear on 7/14/11 and on 8/28/11. The Care plan fails to include fragile skin/skin tears and a prevention plan addressing this. R25's nurses notes written on 8/28/11 at 11:53pm documents that "(Certified Nurses Aide, CNA) reports repositioning in bed - pulling resident up in bed c (with) his assist - grabbed right upper arm to pull up in bed - received skin tear" measuring 4cm x 2cm in half moon shape. The area was cleansed and steri-striped after the physician was notified. The report fails to identify lifting a resident by the upper arm as harmful and fails to include a plan to prevent further skin tears. According to the nurses notes, R25 expired on 8/31/11. Pictures of R25's body received on 9/15/11 from Z4, funeral director, show him to have the skin tear on the upper right arm but also have an open skin tear on his left elbow along with his right great toe which also had a skin tear on. This was confirmed by Z4. The nurses notes contained no information on the right great toe and/or the left elbow. E2, Director of Nursing provided wound care sheets showing that R25 had a left second toe wound but was unable to provide any documentation as to why his right great toe would	F 323		

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have been steri striped or that he sustained an additional skin tear on his left elbow which went undocumented.

4. R22's Occurrence Report, dated 6-4-11 at 02:00, documented "staff (E28, CNA)) had resident in sit to stand was moving her into the bathroom to use toilet when her right upper arm bump the frame of doorway into the bathroom and caused skin tear." It was also noted that her right upper arms was bruised with a skin tear of 1cm.

In an interview of E3, RN, on 9-16-11 at 1:45p.m., E3 stated R22's door frame was checked for sharp edges, R22 was provided a wider high back wheel chair and E15 (CNA) would mentor staff concerning R22's new wheel chair. Interview of E15, on 9-16-11 at 1:56p.m., E15 stated R22 had been provided a new wheel chair, did not inservice concerning the new wheel chair and that E26, Restorative LPN, would address transfers. Interview of E26, on 9-16-11 at 2:01p.m., E26 stated E27, Restorative Aide, inserviced E28 on transfers. Interview of E27, on 9-16-11 at 2:06p.m., stated E28 went on light duty after R22's 6-4-11 transfer and that she did not inservice E28 on transferring.

Interview of E26, on 9-16-11 at 2:01p.m., E26 stated R22's "last assessment of R22's sit to stand transfer was 5-9-11" when asked if R22 had been assessed for the appropriateness of sit to stand transfer after the 6-4-11 incident.

5. R7's MD, dated 7-24-11, documented sever cognitive impairment and extensive assistance of one to two plus persons physical assistance with mobility, transfer and ambulation. R7's Care Plan, target date 11-30-11, documented potential

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for injury related to falls due to impaired cognition physical limitation and lack of safety awareness. It was also noted "clip belt with an alarm while in wheelchair". R7's Care Plan, target date 11-30-11, documented potential for impaired skin integrity. It was also noted "(arm protectors) to be work bilateral upper extremities" and "padded arms of wheelchair for protection."

R7's Occurrence Reports, dated from 4-23-11 to 8-18-11, documented: 4-23-11, 1 cm xc 2cm skin tear on right hand with an intervention to "continue with (arm protectors)"; 5-2-11, 2cm x 2cm skin tear on left thumb with an intervention to "continue with (arm protectors) "; 5-21-11, right hand skin tear with an intervention to "continue with (arm protectors)"; 7-19-11, fall after R7 released her "clip belt" with an intervention to discontinue her "clip belt"; 7-21-11, right elbow bruise with interventions to "place protective (arm protectors) on resident's arms"; and, 8-18-11, right wrist bruise with an interview to provide "long sleeves or (arm protectors).":

R7 was observed, on 9-13-11 and 9-14-11, with her wheel chair "clip belt" in place, the right arm of her wheel chair torn and pieces of torn plastic type material rubbing against her right arm and R7 did not have bilateral "(arm protectors)" or consistently wear long sleeves.

6. R21's MDS, dated 8-17-11, documented an diagnosis, in part, of Alzheimer's and extensive to total dependence of one to two person persons physical assistance with mobility, transfer and ambulation. R21's Occurrence Report, dated 3-19-11 at 15:40, documented "R21 sundowns in evenings and wants to pack up and go home." Per her statement she was looking for her suitcase under her bed and fell. An alarmed mat

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F 323	Continued From page 22 is at bedside and there is a sensor paid on her bed." It was also noted her alarm was not sounding at time of fall. R21's Occurrence reports, dated 3-19-11 to 8-15-11, documented: 3-19-11, at 17:00, R21 fell during unassisted toileting, 3-19-11, at 22:20, R21 was found lying on her back in the middle of the floor and her alarm was not sounding; 3-25-11, at 18:50, left knee abrasion from a fall during unassisted ambulation and her alarm was not sounding; 4-15-11, at 20:55, R21 bumped her head on a dining room chair during unassisted transfer, 6-20-11, at 20:25, R21's roommate informed staff at the nursing station that R21 had fallen after she attempted unassisted ambulation, 6-24-11, at 22:00, R21 fell after an attempted self transfer, 7-18-11, at 22:30, fell from bed and her alarm was not sounding; and, 8-25-11, at 22:10, R21 received a right and left knee abrasion after she was found laying on a mat by her bed. R21's Care Plan, target date 9-30-11, documented potential for injury related to falls due to impaired cognition, limited physical, mobility and lack of safety awareness. It was also noted personal alarm in chair while in room and motion sensor alarm for use while in bed. R21's Care Plan did not document R21's sundowning or interventions related evening activities and fall history.. R21's chart did not document an assessment of the effectiveness of the alarm to prevent falls. Interview of E8, on 9-16-11 at 10:00a.m., E8 stated when R21 would stand up her alarm would go off immediately and staff were not able to assist her in time. E8 did not provide an alarm assessment.	F 323		
F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		10/16/11

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F 329	Continued From page 23 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interviews, observations and record review, the facility failed to adequately monitor for accusatory behaviors; resisting care; the effectiveness including side effects of the Risperdal and the possible link to an overall decline including eating, activities and hygeine/bathing for 2 of 15 residents reviewed for Antipsychotic mecidations in a sample of 26. This failure resulted in R3 showing a decline in	F 329		

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condition as documented on her Minimum Data Set (MDS).

Findings include:

1. According to the Physician's Order Sheet (POS) for September 2011, R3 is receiving Risperdal 1mg at bedtime (HS) which was ordered on 6/23/11 for "Dementia with Behavioral Disturbances" and "Psychotic with Hallucinations." The Minimum Data Set (MDS) Section E BEHAVIORS (5/31/11) identifies R3 as having no hallucinations or delusions and no behavioral symptoms being present. The nurses notes from 4/26/11 through 6/23/11 document only one behavior as occurring on 4/28/11 when R3 was documented as asking for a scissors so she could "cut herself loose."

On 6/21/11, R3 was seen by her primary physician for the monthly visit and documents "according to nursing staff, the patient apparently has been fairly stable." On 6/23/11, the Psychiatrist is documented as seeing her and writes R3 "for an increasing paranoid persecutory bizarre grandiose delusional system, becoming increasingly agitated and accusatory of male staff to the point of having a police investigation when she claimed that staff had raped her." The Psychiatrist ordered Risperdal 1mg daily and increased her Celexa to 40mg daily and added Namenda 20mg and Aricept 10mg daily. There is no justification for the use of the Risperdal as the clinical record including behavioral tracking shows no evidence of continuing behaviors related to staff care. According to the facility's investigation, the accusation appeared as a one time event in which the facility determined to be R3 misunderstanding and confusion with staff

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during incontinent care at night.

On 9/16/11 at 11:45am, E3 Registered Nurse (RN) said R3 has had an increase in behaviors that including resisting care, accusatory behaviors, and increased agitation which resulted in the addition of the Risperdal following the incident of 6/23/11. E3 stated she realized yesterday (9/15/11) that she did not have behavioral tracking sheets out for the right behaviors and has since added those in. Tracking sheets dated 9/16/11 identify R3 as having resisting care issues and making false accusations about people (staff and family).

On 9/16/11 at 10am, R3's family member (Z2) stated R3 had no behaviors that she was aware but did have some adjustments problems on admission which had been over a year ago. Z2 stated she visited R3 often at the facility and was aware that they had started R3 on medication for Alzheimers recently but did not know that the Risperdal was an antipsychotic medication.

On 9/16/11 at 12:40pm, E16, Licensed Practical Nurse (LPN) said R3 "used to have behaviors" but doesn't anymore and provided behavioral tracking sheets from the medication administration records and aides books.

On 9/16/11 at 12:45pm, R15 CNA stated R3 had an incident a couple months ago where she accused the staff but has not had any additional incidents. E15 said "Actually, R3 has had a decline in the past couple months" adding that she used to talk all the time and attend activities and no longer does either. E15 stated she will sit at bedside in her wheelchair with her eyes shut. E15 said R3 will respond when spoken to but doesn't talk like she used to.

On 9/13/11 from 12:55pm until 4pm, R3 was observed to sit at bedside with her eyes shut at

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bedside. R3 was fed the majority of her lunch meal after taking a couple bites by herself with intake being < 25%. R3 was toileted on 9/13/11 at 12:55pm with no resisting behaviors noted and did respond to the CNA's when spoken to. On 9/15/11, from 9am until 11:25am, R3 was again noted to be sitting at bedside in her wheelchair with her eyes closed. R3 was not observed to attend and/or participate in any activities during the survey process.

The MDS dated 8/29/11 fails to identify any behaviors for R3 but reflects a decline in eating from the MDS dated 5/31/11 as setup/supervision to extensive assist, hygiene from minimal to extensive assist and bathing to total dependency on staff.

The Admission sheet for R3 identifies her to be a 92 year old female readmitted to the facility on 12/28/10 with diagnoses of Cerebral Vascular Disease, Hemiplegia, hypertension and depression.

2. R10's POS shows an order of 2-28-11 for .5 mg of Risperdal. R10's MDS of 8-6-11 shows no behaviors. Record review of R10's PSYCHOACTIVE MEDICATION MONTHLY FLOW RECORDS for June, July and August 2011 show R10 receives Risperidone .5 mg for delusions. Flow records show documentation of no delusions.

During interview with E3, on 9-15-11 at 3:45PM, E3 confirmed R10 is not having delusions and stated they had just decreased R10's Risperdal not too long ago.

In the morning of 9-16-11, E2, Director of Nursing, provided a Consultant Pharmacist Communication to Physician form dated 9-4-11 with recommendation to reduce the Risperdal

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F 329	Continued From page 27 with an order dated 9-16-11 from R10's Physician to lower the Risperdal to .25 mg.	F 329		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		10/16/11

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F 441	Continued From page 28 infection. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure good handwashing during care for 2 of 12 residents, R2 and R10, reviewed for catheter care/incontinent care, in the sample of 26. Findings include: 1. Record review of R2's September Physician Order Sheet documents R2 has a indwelling urinary catheter. R2's POS shows an order for Levaquin 250 mg daily on 9-7-11 for a UTI. R2 was observed on 9-14-11 at 10:10AM to be incontinent of bowel and had a urinary catheter. E22 and E23, Certified Nurse Aides (CNA's) were observed to do incontinent care. R23 was observed to handle R2's new incontinent brief and blanket with the same soiled gloves she had worn while doing incontinent care. 2. Record review of R10's Minimum Data Set of 8-6-11 identifies R10 is incontinent of bowel and bladder. On 9-14-11 at 1:45PM, E25 was observed to give incontinent care to R10. R10 had been incontinent of urine and a large amount of loose feces. E25 had a basin of water, peri wash and dry wash clothes. E25 wet a wash cloth, apply peri wash and would wipe feces from R10 repeatedly without changing her gloves. E25 was observed to touch R10's clean blanket, bed frame	F 441		

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F 441	Continued From page 29 and R10's body during repositioning while wearing the same soiled gloves.	F 441		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.610a) 300.1210d)5) 300.3240a) 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 Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not	F9999		

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develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

Based on observation, interview and record review, the facility failed to consistently and accurately assess, monitor and implement new treatments for pressure sores to prevent decline for 3 of 5 residents (R2, R3 and R14) reviewed for pressure sores in a sample of 26. This failure resulted in R2 having a decline and increase in size in her pressure sore from purple non-blanchable area on her heel to an unstageable pressure sore with full thickness loss with drainage. This failure resulted in R3 developing an avoidable pressure sore on her right trochanter that facility did not identify, assess and treat until it was unstageable.

Findings include:

1. Record review of R2's Admission Sheet of 8-15-11 shows documentation that R2 was readmitted to the facility from the hospital with purple non-blanchable area on her left heel.
Record review of R2's ULCER Care Plan - Treatment Plan of 8-15-11 documents a pressure sore on R2's left heel with an "X" next to stage 1 "Non-blancheable erythema, discolor dark skin or warmth/edema/induration. Skin

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intact. Size: length; 3 width:2.5 Drainage: none" An undated note under Initial Entry Note: had documentation, "DTI (deep tissue injury) to L (left heel, waffles to feet, et (and) floated, area dark brown, boggy et intact. Dr (Doctor) updated for skin prep order." On 9-16-11 at 11AM, E13 (Treatment Nurse) stated she had written the note concerning DTI on 8-18-11. (R2's Treatment Administration Record (TAR) show the facility did not start treatment until 8-22-11 when order was obtained for skin prep and cover with Allevyn heel dressing and Kling. This was 7 days after a stage 1 was identified and 4 days after DTI was assessed.)

The next assessment of 8-25-11 on the ULCER - Treatment Plan, shows pressure sore measured 3.2 x 3.1 cm with <0.1 cm depth with scant Serosanguinous drainage and is red in color. A note is written with documentation: "Necrotic tissue off, 100% red dermis, 0 undermining, 0 tunneling cont (continue) current TX"

The next assessment of 9-1-11 documents pressure sore is 3 x 3 cm with superficial depth and no drainage and red in color. Note "100% red dermis heel protector in place cont current tx."

The next assessment of 9-8-11 shows documentation that the pressure sore is 3.2 x 3 cm unstageable 0.1 black. Note states to continue same treatment.

The next assessment of 9-15-11 shows documentation that pressure sore is 3 x 3 cm with <0.1 depth with scant serosanguinous drainage ane 0.8 x 0.5 red dermis and .4 x .6 black. Note documents Physician was notified on 9-15-11.

R2 was observed on 9-14-11 at 10:10AM to be in bed and had an Allevyn heel and Kirlex on her left heel. E14, Licensed Practical Nurse (LPN)

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removed the dressing from R2's heel. The Allevyn heel was stuck to the wound and there was dark brown drainage. The pressure sore was beefy red with edges that were black in some areas. The beefy red area was a full thickness wound. E14 cleansed the wound with wound cleanser and gauze and then put R2's heel down on the pillow at the foot of her bed. E14 then opened a Sureprep wipe and wiped around and over the pressure sore. E14 fanned R2's heel until Sureprep dried and then placed a gauze pad in the same soiled Allevyn heel and placed the dressing on R2's heel. E14 was asked if she was using the same dressing that she just took off and E14 confirmed she had used the same Allevyn heel. E14 then stated maybe she shouldn't and took the dressing off R2's heel, took out the gauze pad and confirmed the Allevyn was soiled with brown drainage. E14 then placed R2's ankle on the pillow and told her not to let the pillow touch her heel. E14 left the room to get supplies and when she came back, R2 had rearranged her foot and the pressure sore was touching the pillow. E14 put a new gauze pad into a new Allevyn heel, put the dressing on R2's heel and dressed with kling without re cleansing the pressure sore.

On 9-15-11 at 10:25AM, E13 stated R2's heel was red when first admitted and then identified as DTI. E13 confirmed R2 has not had a treatment change. E13 stated she had just today, sent information to the Doctor to see if they could change the treatment order. At 1:40PM, E13 stated the pressure sore was a full thickness skin loss with partial brown edges and had been like that for about a week.

According to the manufacturer's information for Sureprep, provided by the facility on 9-15-11,

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Sureprep is for management of healing wounds to provide an additional barrier to the delicate skin around a wound during the healing process.
During an interview on 9-15-11 at 9:45AM, with Z3, Certified Wound Specialist/Nurse for Sureprep, Z3 stated the only time Sureprep is to be used is to protect intact skin. It should not be used on full thickness loss. It's contraindicated for full thickness loss wounds.
Record review of Nurses Notes from 8-15-11 through 9-14-11 shows no documentation that R2's Physician was contacted of decline in the pressure sore. Physician order sheets from 8-22-11 through 9-14-11 show there was no change in treatment order even though the pressure sore on the left heel showed a decline.

Nutrition Assessment of 8-24-11 shows R2 was admitted on 8-15-11 with a weight of 130 lbs and a DWR (desired weight range) of 97-138 lbs. The Assessment shows history of poor intake and estimated intake < 25%. Assessment documents general mechanical diet is adequate to meet nutritional needs, area on left heel DTI; poor intake with recommendation for supplement due to weight loss and open area. R2's TAR shows R2 weighed 118 lbs on 9-1-11 and 9-7-11 yet there in no Nutritional Assessment address the significant weight loss or the decline in pressure sore. The Facility was informed of concern on 9-14-11 and had the Dietitian assess on 9-15-11 with recommendation for increased nutritional supplement.

R2's laboratory test of 9-7-11 show total protein and albumin are within normal limits.
During interview with E19, LPN, on 9-15-11 at 3:45PM, E19 stated she does treatments to R2's heel. E19 stated when she first saw R2's left heel it was a blister. E19 states its now real beefy red

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with brown dried edges. She said she changes the dressing every night when she works. Last week the blister broke and they were still using skin prep (Sureprep) to the heel. The heel didn't seem to be improving over the weekend. E19 stated she felt the skin prep was not working and the pressure sore was getting worse. E19 felt the treatment needed to be changed and on Sunday, September 11, 2011, she let the night Nurse so the Physician could be notified.
Nurses Notes of 9-14-11 at 2325 document R2's Physician was faxed update with regards to treatment to left heel - no improvement. Fax provided by E21, Corporate Nurse, showed Fax Communication form dated 9-15-11 at 0730 sent to R2's Physician documenting R2 "has current order for skin prep L heel. Area now open can we DC (discontinue) current order et change to cleanse dly (daily with normal saline or wound wash, apply silvasorb gel to open area Cover with foam pad et wrap with kerlix?" Fax was signed with OK and sent back to the facility on 9-15-11 at 1431.

2. According to Minimum Data Set (MDS) dated 8/29/11, R3 requires extensive assist of staff for transfers and bed mobility and is frequently incontinent of bladder. The Braden Scale dated 8/31/11 identifies R3 as a "moderate risk" for pressure ulcer development. Labs dated 4/13/11 indicate Albumin is 2.6 (normal 2.4 - 4.3) and Total Protein 5.7 (Normal 5.1 - 7.2) are both normal. The Registered Dietician identified a weight gain of 5 pounds on 8/18/11. The Physician's Order sheet (POS) for September 2011 indicates R3 receives Med Pass 120cc three times daily. The care plan dated 7/14/11 identifies R3 at risk for skin breakdown.

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The Pressure Ulcer weekly report identifies R3 as developing an in-house acquired ulcer on her right trochanter on 8/21/11. The nurses notes also reflect the pressure sore and indicates it measured 1.6cm x 1.4cm with a necrotic area in the center measuring 0.5cm x 0.2cm, stage III. There is no justification for the development of this ulcer and no explanation as to why the area was not identified prior to the development of the necrotic area. The "Weekly Ulcer Report" dated 9/1/11 reflects the initial ulcer on the right trochanter and an additional ulcer developing in the same area which measured 1.0cm x 0.2 staged at a II which began as a blister.

On 9/16/11 at 10:30am, E2 Director of Nursing (DON) identified R3 as being on Hospice and the pressure ulcers being "unavoidable" offering documentation, Clinically unavoidable pressure sore guide tool", that lists R3 as having Hemiplegia and chronic urinary incontinence and having labs that indicate R3 may be at risk for malnutrition and/or dehydration/poor healing. The tool also includes interventions implemented at the time the ulcer were identified but don't include any reference to her right side. Interview with E15, Certified Nurses Aide, said on 9/16/11 at 12:45pm, that R3 has declined in the past couple months and always insists on laying on her right side when in bed so she can face the wall.

R3 was observed to sit in her chair at bedside and/or in the dining room throughout the survey except for toileting.

The ULCER POLICY & PROCEDURE indicates all residents will be assessed upon admission, quarterly and as changes occur. The policy includes protocol for low, moderate and high risk residents. Moderate risk indicates "Daily skin

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checks are completed, as well as weekly skin checks by CNA (Certified Nurses Aide) on bath day using the "skin observation worksheet." The policy continues under HIGH RISK to document that "residents with existing ulcers will be scored at high risk automatically." There is no documentation that R3 was reassessed for risk following the development of the stage III pressure ulcer.

3. The Facility Care Plan with the target date of 10/28/11 documents that R14 has diagnoses that include; Diabetes Mellitis, Hypertension, Depressive Disorder, Senile Dementia and generalized pain. Review of the care plan problem area of skin, dated 8/30/11 documents a stage one pressure ulcer to the right heel and stage two pressure area to the left heel. Under the area of goals is documented "right heel discontinued on 9/7/11 and 9/8/11." Review of the current MDS dated 7/14/11 documents that R 14 requires extensive assistance with all activities of daily living, is non- ambulatory and uses a wheelchair. She is also assessed as being at risk for pressure ulcers and requires pressure relieving devices in bed and in the chair. Review of the Facility "Weekly Ulcer Report" for the week of 9/1/11 documents that R14 has a Stage one pressure ulcer to the right heel measuring 2.5 by 1.7 centimeters, and a stage two pressure ulcer to the left heel measuring 0.5 by 0.3. The Weekly Ulcer Report dated 9/8/11 documents that R14's Right heel wound is resolved and the left heel measures 2.1 by 2.5 centimeters. There is no documentation of any dressing to R 14's coccyx area.

A skin check done with E20 Registered Nurse,

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F9999	Continued From page 37 on 9/14/11 at 4:30PM. Observed that Right heel has a darkened area, firm to the touch, and non-blanching. E20 stated, " there is still something there so we should be tracking that until it is gone." Skin check with E16 on 9/14 /11 at 4:00PM. R 14 was observed to have an occlusive dressing area applied to her coccyx. When the dressing was removed, the entire coccyx was reddened and towards the center were several open areas with skin peeling back in small sections. E 16 stated, "well I asked the wound care nurse about this dressing because we didn't have any for (R14), and she stated, hospice has been putting that on because of irritation due to incontinence. No we have not been tracking or measuring that area." (B) 300.610a) 300.610c)2) 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)2)6) 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.	F9999		

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F9999	Continued From page 38 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 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological	F9999		

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F9999	Continued From page 39 well-being of the resident, in accordance with each resident's comprehensive resident care plan. 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. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 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. Based on interviews, observations and record review, the facility failed to ensure residents receive adequate supervision and proper assistance to prevent falls and skin tears for 6 residents R7, R17, R19, R21, R22 and R25 of 15 residents reviewed for falls and bruises/abrasions in the sample of 26. The failure resulted in R19 obtaining a left hip fracture.	F9999		

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F9999	Continued From page 40 Findings include: 1. The Minimum Data Set (MDS) dated 04/13/11 documents R19 as having short/long term memory deficits with moderate cognitive impairment and requires assist of one staff for mobility. The Fall Assessment dated 03/21/11 identifies R19 at a moderate risk for falls. The Care Plan dated 04/12/11 identifies R19 as needing assistance of one with a gaitbelt and wheeled walker with transfers, ambulation to/from bathroom and walking in corridor. The Occurrence Report dated 04/10/11 at 8:55 AM, documented R19 was "observed sitting on floor in the resident's room." The report further documented cognitive level of "oriented x 2" and "no injuries noted." On 04/10/11 at 8:00 PM, additional information was documented as "skin tear 3.5 x 2.5 x 0" and a resident statement was given as "I was reaching for my coffee cup earlier today and there was stuff in the way and I must of hit my arm then." Treatment documented as "Steri strips applied." Interventions documented on the report as "Will look at room to arrange area for resident to put coffee and other items within easy reach. Will continue to monitor area until resolved. Will have maintenance look at room for any sharp edges to help prevent future skin tears." Another Occurrence Report dated 04/22/11 at 7:31 PM, documented R19 was "observed on floor in dining room." The report further documented cognitive level of "oriented x 1" and "pain when ROM performed, resident complained of left hip/leg pain, outside services required."	F9999		

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Documentation indicated that R19 was transported via ambulance to the hospital. Hospital documentation indicated that R19 sustained a Left Hip Femoral Neck Fracture and underwent Left Hip Hemiarthroplasty. Nurses Notes indicated that R19 was repeatedly walking without assist of staff and/or walker days and the evening approaching the fall on 04/22/11. On 04/28/11, R19 was readmitted to the Facility. On 04/28/11, the Care Plan indicated "personal alarm" was added as an intervention.

On 09/13/11 at 10:30 AM, E24, LPN, stated the Facility attributed the fracture to a fall on 04/22/11.

On 05/03/11 at 11:50 PM, an Occurrence Report documented that R19 was "observed on floor in resident's room, laying along side of bed on back." The report documented prevention measures at the time of fall "Alarm: None." R19's cognitive level was documented as "oriented x 1." The report documented "Immediate Actions Taken:...Alarm applied." There was no further changes made to the Care Plan at this time.

On 05/12/11, the "Endurance/Functional Ability Assessment" documented R19 "transfers with extensive assist of 1-2 using gait belt and wheeled walker...Extensive assist for toileting, bed mobility, dressing and personal hygiene also..."

On 08/20/11 at 12:30 AM, an Occurrence Report documented that R19 was "observed on floor on his back with his head near closet in resident's room." The prevention measures at the time of fall "Alarm: none." The report documented

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resident statement "I don't know for sure but I think that I lost my balance and fell. It made my bad hip start hurting again." Documentation indicated that R19 was transferred via ambulance to the hospital for treatment and returned later the same day. On 08/24/11, after many complaints of pain of the left hip/leg by R19, R19 was transferred to the hospital and admitted with the diagnoses of Anemia and Urinary Tract Infection.

2. Per the admissions face sheet R17 has current diagnoses which include; Cerebral Vascular Accident, Transient Ischemic Attack, Senile Dementia, Insomnia and Acute and Chronic Urinary Tract Infections. The most recent MDS dated 7/11/11 documents that R 17 is severely cognitively impaired, with both short and long term memory problems. The Facility Fall Assessment dated 7/10/11 documents that R 17 is at high risk for falls. The Plan of Care with the Target date of 10/25/11 under the problem area of Mobility deficits does not include any connection to R17's Urinary Tract Infections (UTI) or UTI symptoms that warrant interventions or the need to increase supervision for R17 during these times.

Facility Occurrence reports dated 10/12/10, 1/30/11, 3/8/11, 5/31/11 6/2/11, 6/25/11, 7/15/11, 8/28/11 and 8/30/11 document that R17 had repeated falls. The Facility Occurrence report dated 6/2/11 states, " Fell out of Broda Chair while at the nurses station, no witnesses." The intervention recommendation for this incident states, "Current Broda Chair to be replaced with drop seat wheelchair and self releasing seat belt." The 6/25/11 Occurrence Report states, "fell on floor next to Broda chair out in common area, no witnesses, head trauma noted...abrasion." No

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changes in care interventions were provided by the facility between the 6/2 fall and the 6/25 fall. The Facility occurrence report dated 8/28/11 documents R17 fell out of her bed on to the mat at the bedside. Facility Recommendations were to, "continue current safety measure and re-evaluate effectiveness." R 17 fell again on 8/30/11 from her bed to the mat on the floor. This fall per the report resulted in a head injury. No changes in care interventions had been made between the 8/28 and 8/30/11 fall.

Facility follow up written by E3,RN, on 8-31-11, notes that R 17 "had an elevated temperature and increased restlessness with frequent attempts to toilet herself. Recommendations state, continue current safety measure which are effective when (R17) does not have a Urinary Tract infection." There are no interventions/recommendations given on the occurrence report or on the current care plan for increased supervision when R 17 states to display signs/symptoms of a Urinary Tract Infection.

E17, LPN, stated during the facility tour on 9/13/11 at 10:30 AM that the bruise was a result of R17's most recent fall dated 8/30/11.

On 9/13/11 at 11:30AM, E3 stated "yes she got the bruise as a result of that fall, we know she has these falls when she gets a urinary tract infection. She gets more restless and agitated, and crawls out of bed or out of her chair."

On 9/13/11 at 11:30am, R17 was observed in her Broda chair in the dining room at the table. R17's left side of her face was black/blue/purple extending from her hairline to her upper neck

3. R25 nurses notes indicate he sustained a skin tear on 7/14/11 and on 8/28/11. The Care plan

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fails to include fragile skin/skin tears and a prevention plan addressing this.

R25's nurses notes written on 8/28/11 at 11:53pm documents that "(Certified Nurses Aide, CNA) reports repositioning in bed - pulling resident up in bed c (with) his assist - grabbed right upper arm to pull up in bed - received skin tear" measuring 4cm x 2cm in half moon shape. The area was cleansed and steri-striped after the physician was notified.

The report fails to identify lifting a resident by the upper arm as harmful and fails to include a plan to prevent further skin tears.

According to the nurses notes, R25 expired on 8/31/11. Pictures of R25's body received on 9/15/11 from Z4, funeral director, show him to have the skin tear on the upper right arm but also have an open skin tear on his left elbow along with his right great toe which also had a skin tear on. This was confirmed by Z4. The nurses notes contained no information on the right great toe and/or the left elbow.

E2, Director of Nursing provided wound care sheets showing that R25 had a left second toe wound but was unable to provide any documentation as to why his right great toe would have been steri striped or that he sustained an additional skin tear on his left elbow which went undocumented.

4. R22's Occurrence Report, dated 6-4-11 at 02:00, documented "staff (E28, CNA)) had resident in sit to stand was moving her into the bathroom to use toilet when her right upper arm bump the frame of doorway into the bathroom and caused skin tear." It was also noted that her right upper arms was bruised with a skin tear of 1cm.

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F9999	Continued From page 45 In an interview of E3, RN, on 9-16-11 at 1:45p.m., E3 stated R22's door frame was checked for sharp edges, R22 was provided a wider high back wheel chair and E15 (CNA) would mentor staff concerning R22's new wheel chair. Interview of E15, on 9-16-11 at 1:56p.m., E15 stated R22 had been provided a new wheel chair, did not inservice concerning the new wheel chair and that E26, Restorative LPN, would address transfers. Interview of E26, on 9-16-11 at 2:01p.m., E26 stated E27, Restorative Aide, inserviced E28 on transfers. Interview of E27, on 9-16-11 at 2:06p.m., stated E28 went on light duty after R22's 6-4-11 transfer and that she did not inservice E28 on transferring. Interview of E26, on 9-16-11 at 2:01p.m., E26 stated R22's "last assessment of R22's sit to stand transfer was 5-9-11" when asked if R22 had been assessed for the appropriateness of sit to stand transfer after the 6-4-11 incident. 5. R7's MD, dated 7-24-11, documented sever cognitive impairment and extensive assistance of one to two plus persons physical assistance with mobility, transfer and ambulation. R7's Care Plan, target date 11-30-11, documented potential for injury related to falls due to impaired cognition physical limitation and lack of safety awareness. It was also noted "clip belt with an alarm while in wheelchair". R7's Care Plan, target date 11-30-11, documented potential for impaired skin integrity. It was also noted "(arm protectors) to be work bilateral upper extremities" and "padded arms of wheelchair for protection." R7's Occurrence Reports, dated from 4-23-11 to 8-18-11, documented: 4-23-11, 1 cm xc 2cm skin tear on right hand with an intervention to "continue with (arm protectors)"; 5-2-11, 2cm x	F9999		

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2cm skin tear on left thumb with an intervention to "continue with (arm protectors) "; 5-21-11, right hand skin tear with an intervention to "continue with (arm protectors)"; 7-19-11, fall after R7 released her "clip belt" with an intervention to discontinue her "clip belt"; 7-21-11, right elbow bruise with interventions to "place protective (arm protectors) on resident's arms"; and, 8-18-11, right wrist bruise with an interview to provide "long sleeves or (arm protectors).":

R7 was observed, on 9-13-11 and 9-14-11, with her wheel chair "clip belt" in place, the right arm of her wheel chair torn and pieces of torn plastic type material rubbing against her right arm and R7 did not have bilateral "(arm protectors)" or consistently wear long sleeves.

6. R21's MDS, dated 8-17-11, documented an diagnosis, in part, of Alzheimer's and extensive to total dependence of one to two person persons physical assistance with mobility, transfer and ambulation. R21's Occurrence Report, dated 3-19-11 at 15:40, documented "R21 sundowns in evenings and wants to pack up and go home." Per her statement she was looking for her suitcase under her bed and fell. An alarmed mat is at bedside and there is a sensor paid on her bed." It was also noted her alarm was not sounding at time of fall.

R21's Occurrence reports, dated 3-19-11 to 8-15-11, documented: 3-19-11, at 17:00, R21 fell during unassisted toileting, 3-19-11, at 22:20, R21 was found lying on her back in the middle of the floor and her alarm was not sounding; 3-25-11, at 18:50, left knee abrasion from a fall during unassisted ambulation and her alarm was not sounding; 4-15-11, at 20:55, R21 bumped her head on a dining room chair during unassisted

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F9999	Continued From page 47 transfer, 6-20-11, at 20:25, R21's roommate informed staff at the nursing station that R21 had fallen after she attempted unassisted ambulation, 6-24-11, at 22:00, R21 fell after an attempted self transfer, 7-18-11, at 22:30, fell from bed and her alarm was not sounding; and, 8-25-11, at 22:10, R21 received a right and left knee abrasion after she was found laying on a mat by her bed. R21's Care Plan, target date 9-30-11, documented potential for injury related to falls due to impaired cognition, limited physical, mobility and lack of safety awareness. It was also noted personal alarm in chair while in room and motion sensor alarm for use while in bed. R21's Care Plan did not document R21's sundowning or interventions related evening activities and fall history.. R21's chart did not document an assessment of the effectiveness of the alarm to prevent falls. Interview of E8, on 9-16-11 at 10:00a.m., E8 stated when R21 would stand up her alarm would go off immediately and staff were not able to assist her in time. E8 did not provide an alarm assessment. (B) 300.686a) 300.686c) 300.686d) 300.1210b)4)5) 300.1210d)3) 300.3240a) Section 300.686 Unnecessary, Psychotropic, and	F9999		

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F9999	Continued From page 48 Antipsychotic Drugs a) A resident shall not be given unnecessary drugs in accordance with Section 300.Appendix F. In addition, an unnecessary drug is any drug used: 1) in an excessive dose, including in duplicative therapy; 2) for excessive duration; 3) without adequate monitoring; 4) without adequate indications for its use; or 5) in the presence of adverse consequences that indicate the drugs should be reduced or discontinued. (Section 2-106.1(a) of the Act) c) Residents shall not be given antipsychotic drugs unless antipsychotic drug therapy is necessary, as documented in the resident's comprehensive assessment, to treat a specific or suspected condition as diagnosed and documented in the clinical record or to rule out the possibility of one of the conditions in accordance with Section 300.Appendix F. d) Residents who use antipsychotic drugs shall receive gradual dose reductions and behavior interventions, unless clinically contraindicated, in an effort to discontinue these drugs in accordance with Section 300.Appendix F. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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 resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	F9999		

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F9999	Continued From page 49 resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mentaland emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146059	A. BUILDING _____ B. WING _____	09/16/2011

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Based on interviews, observations and record review, the facility failed to adequately monitor for accusatory behaviors; resisting care; the effectiveness including side effects of the Risperdal and the possible link to an overall decline including eating, activities and hygeine/bathing for 2 of 15 residents reviewed for Antipsychotic mecidations in a sample of 26. This failure resulted in R3 showing a decline in condition as documented on her Minimum Data Set (MDS).

Findings include:

1. According to the Physician's Order Sheet (POS) for September 2011, R3 is receiving Risperdal 1mg at bedtime (HS) which was ordered on 6/23/11 for "Dementia with Behavioral Disturbances" and "Psychotic with Hallucinations." The Minimum Data Set (MDS) Section E BEHAVIORS (5/31/11) identifies R3 as having no hallucinations or delusions and no behavioral symptoms being present. The nurses notes from 4/26/11 through 6/23/11 document only one behavior as occurring on 4/28/11 when R3 was documented as asking for a scissors so she could "cut herself loose."

On 6/21/11, R3 was seen by her primary physician for the monthly visit and documents "according to nursing staff, the patient apparently has been fairly stable." On 6/23/11, the Psychiatrist is documented as seeing her and writes R3 "for an increasing paranoid persecutory bizarre grandiose delusional system, becoming increasingly agitated and accusatory of male staff to the point of having a police investigation when

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she claimed that staff had raped her." The Psychiatrist ordered Risperdal 1mg daily and increased her Celexa to 40mg daily and added Namenda 20mg and Aricept 10mg daily. There is no justification for the use of the Risperdal as the clinical record including behavioral tracking shows no evidence of continuing behaviors related to staff care. According to the facility's investigation, the accusation appeared as a one time event in which the facility determined to be R3 misunderstanding and confusion with staff during incontinent care at night.

On 9/16/11 at 11:45am, E3 Registered Nurse (RN) said R3 has had an increase in behaviors that including resisting care, accusatory behaviors, and increased agitation which resulted in the addition of the Risperdal following the incident of 6/23/11. E3 stated she realized yesterday (9/15/11) that she did not have behavioral tracking sheets out for the right behaviors and has since added those in. Tracking sheets dated 9/16/11 identify R3 as having resisting care issues and making false accusations about people (staff and family).

On 9/16/11 at 10am, R3's family member (Z2) stated R3 had no behaviors that she was aware but did have some adjustments problems on admission which had been over a year ago. Z2 stated she visited R3 often at the facility and was aware that they had started R3 on medication for Alzheimers recently but did not know that the Risperdal was an antipsychotic medication.

On 9/16/11 at 12:40pm, E16, Licensed Practical Nurse (LPN) said R3 "used to have behaviors" but doesn't anymore and provided behavioral tracking sheets from the medication administration records and aides books.

On 9/16/11 at 12:45pm, R15 CNA stated R3

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had an incident a couple months ago where she accused the staff but has not had any additional incidents. E15 said "Actually, R3 has had a decline in the past couple months" adding that she used to talk all the time and attend activities and no longer does either. E15 stated she will sit at bedside in her wheelchair with her eyes shut. E15 said R3 will respond when spoken to but doesn't talk like she used to.

On 9/13/11 from 12:55pm until 4pm, R3 was observed to sit at bedside with her eyes shut at bedside. R3 was fed the majority of her lunch meal after taking a couple bites by herself with intake being < 25%. R3 was toileted on 9/13/11 at 12:55pm with no resisting behaviors noted and did respond to the CNA's when spoken to. On 9/15/11, from 9am until 11:25am, R3 was again noted to be sitting at bedside in her wheelchair with her eyes closed. R3 was not observed to attend and/or participate in any activities during the survey process.

The MDS dated 8/29/11 fails to identify any behaviors for R3 but reflects a decline in eating from the MDS dated 5/31/11 as setup/supervision to extensive assist, hygiene from minimal to extensive assist and bathing to total dependency on staff.

The Admission sheet for R3 identifies her to be a 92 year old female readmitted to the facility on 12/28/10 with diagnoses of Cerebral Vascular Disease, Hemiplegia, hypertension and depression

2. R10's POS shows an order of 2-28-11 for .5 mg of Risperdal. R10's MDS of 8-6-11 shows no behaviors. Record review of R10's PSYCHOACTIVE MEDICATION MONTHLY FLOW RECORDS for June, July and August

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F9999	Continued From page 53 2011 show R10 receives Risperidone .5 mg for delusions. Flow records show documentation of no delusions. During interview with E3, on 9-15-11 at 3:45PM, E3 confirmed R10 is not having delusions and stated they had just decreased R10's Risperdal not too long ago. In the morning of 9-16-11, E2, Director of Nursing, provided a Consultant Pharmacist Communication to Physician form dated 9-4-11 with recommendation to reduce the Risperdal with an order dated 9-16-11 from R10's Physician to lower the Risperdal to .25 mg. (B)	F9999		