STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145439	A. BUILDING _____ B. WING _____	10/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN URBANA REG REHAB CENTER	302 WEST BURWASH SAVOY, IL 61874

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Complaint Investigation 1162601/IL54228 - F323 Validation Survey for Subpart U: Alzheimer's Unit Extended Survey conducted	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164		11/3/11

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

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This REQUIREMENT is not met as evidenced by:
Based on observations and interview, the facility failed to provide privacy during personal care to 4 of 27 sampled residents (R12, R16, R22, R23).

Findings include:

1. On 9/27/11 at 11:40am E31 and E32, Certified Nurse Aide's(CNA's) provided incontinence care to R16. E31 pulled the privacy curtain, but the curtain was not pulled enough to shield R16's exposed perineal area from being seen by anyone passing by in the hallway. The door to the hall was opened several times during the incontinence care. On 9/27/11 at 11:45am E32 stated the privacy curtain didn't seem to be long enough to shield R16 from the door to the hallway.

2. On 9/28/11 at 8:40am E35, ADON(Assistant Director of Nursing) and E40, Physical Therapist was in R23's room working with R23. The room door was standing wide open and R23 was rolled onto his side facing away from the door. R23 was noted at that time to be exposed from the waist down to his legs. You could see the backs of his legs, the incontinent brief he was wearing and the care being given, from the hall way.

3. On 9/27/11 at 10:00am E34, Licensed Practical Nurse(LPN) did R12's treatment to the coccyx. After completing R12's treatment, E34 went into the adjoining resident bathroom to wash her hands. E34 did not knock before entering the bathroom, and another resident(R22) was sitting

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F 164	Continued From page 2 on the toilet. Even though the bathroom was occupied by R22, E34 went ahead and washed her hands before leaving the bathroom. 4. On 9/26/11 at 10:30am during the initial tour of the facility R12 was seated on a shower chair in the hall after receiving a shower. R12 was not totally covered while sitting in the hall, and both of her naked thighs were exposed. 5. On 9/29/11 at 4:30pm, R37 was standing at the medication cart reading the nursing report from first shift given to the 2nd shift nurse on first floor north hall.	F 164		
F 223 SS=G	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure facility staff were trained in appropriate interventions for wandering residents, resulting in involuntary seclusion being used as an intervention to confine two sampled wandering residents to their room (R21,R17), in a sample of 27. Locked mechanical lifts were used to block the doors of the room and bathroom to prevent R21 and R17 from exiting their room. Both residents were unable to leave the blocked room	F 223	Past noncompliance: no plan of correction required.	

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F 223	Continued From page 3 entrances and were unreasonably restricted from being able to freely access surroundings outside of their room. This past noncompliance occurred from 9/12/10 to 10/6/10. Findings include: The facility letter titled "Resident Abuse" dated 9/24/11 states, "[Z4, Head of Staffing Agency] reported.....that her staff[Z2,Licensed Practical Nurse,LPN and Z3, Registered Nurse, RN] told her that back on 9/12/10, [E12, Certified Nurse Aide, CNA] placed lifts in front of the room and bathroom doors to [R21's] room to block him in the room.....[E12] was in today and stated he was the only person on the hall that night, 'the other CNA was on break, and I needed to do my bed checks.'.....According to another CNA[E13], [E12] blocked the room door with the sit to stand lift and when she[E13] saw the door was closed [E13] knocked on the door and tried to open it. [E13] could not push the door open and went in through the next room to enter through bathroom door. That door was blocked with a [mechanical] lift. When [E13] entered the room, [R21] and his roommate[R17] were both awake, up and walking in the room....." The undated statement written by E13, CNA, stated, "I was looking for help to transfer a resident....I was walking down the hall and noticed [R21's] door was closed, so I knocked on the door and tried to open, but couldn't, so I went to [adjoining] room, there was a [mechanical] lift locked and pushed up against the bathroom door, so [R21,R17 in the adjoining] room couldn't get	F 223		

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out of the room. After moving that[the lift] I entered [R21's] room to find a sit to stand lift locked in front of residents[R21,R17] door. Both [R21,R17] were up and trying to get out....." The statement documents the incident occurred on 9/12/10 at 3:00am.

E13, CNA, stated on 9/29/11 at 11:20am that she went to the south hall to find someone to help her transfer another resident, but was unable to find anyone. E13 stated she saw the door to R21's room was shut, so she thought staff was in the room. E13 stated, "I couldn't get [R21's] door to open. I went into the next room-the [mechanical] lift was against the adjoining bathroom door. I moved the [mechanical] lift and got into [R21's] room. [R21 and R17] were both up. The sit to stand lift was in front of the [room] door-it was locked in place."

The documentation of an interview of E12, CNA by E2, Director of Nursing(DON) dated 9/28/10 states, "I think it was 2:00am, [E11,CNA] was on break....No one was able to watch [R21], so I put the stand lift in front of the door-just the room door. I did this so I could do my bed check....." E12 stated on 9/29/11 at 11:25am that he does not remember anything about the incident(9/12/10).

The undated statement written by E45, RN states, ".....[E12] said all the CNA's were gone and [R21] was being aggressive and trying to get out of his room-he[E12] said he was trying to keep [R21] safe, so he was trying to figure out what he could do to take care of [R21] and all the other residents, so [E12] put a lift in front of the door.....I know [R21] was up quite a bit

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that nt[night]- going up and down the hall and kept going to the DR[dining room]....When the other nurse told [E12] that was the wrong thing to do, [E12] seemed very remorseful-didn't realize it was wrong, just wanted [R21] to be safe....."

E11, CNA, stated on 9/29/11 at 11:25am she was on break when the incident(9/12/10) occurred. E11 stated that R21 can be very violent and has punched other residents, but got along well with R17. E11 stated that "normally someone just stayed with [R21], light duty staff did a one to one with [R21], but that night[9/12] it was just [E12] and I on the hall...so we had to monitor [R21] as well as take care of [other] residents." E11 stated there were 30 other residents residing on the hall. When asked if E12 had barricaded R21 in the room any other time, E11 stated, "I believe it happened[involuntary seclusion] one other time and then [E12] was suspended. I heard it from the nurse's again, after the last incident he[E12] was suspended." E11 was unable to recall what nurse told her about the involuntary seclusion happening again.

Z3, Agency RN, stated on 9/29/11 at 11:00am stated they had a long discussion about involuntary seclusion with staff that night(9/12/10) and "don't do that because [R21] roams." Z3 stated that "[E12] thought he did nothing wrong." Z3 stated she was not aware of the involuntary seclusion occurring any other time.

E2, DON, stated on 9/29/11 at 1:00pm that she was unaware of the involuntary seclusion occurring anytime except the one time on 9/12/10. E2 stated, "I remember he[E12] believed he was trying to keep [R21] safe and did not see

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F 223	Continued From page 6 it as abuse." E2 confirmed that E12 was terminated for the involuntary seclusion of R21 and R17. The Physician's Order Sheet(POS) dated September 2011 states R21 has a diagnosis of Dementia with Behaviors. The Minimum Data Set(MDS) dated 7/30/10 states R21 has cognitive and memory problems, resists care and is independent with ambulation/transfers. The September 2010 Behavior Tracking Form documents behaviors of anger, physical and verbal aggression. The POS dated September 2011 states R17 has a diagnosis of Dementia. The MDS dated 9/15/10 states R17 has cognitive impairment, behaviors of wandering, anger, resisting care and requires supervision for ambulation. The facility took the following measures to correct the non-compliance: All staff was re-educated on the Abuse policy. A Quality Assurance audit was completed on 10/6/10 for all nursing employees, consisting of employees being able to verbalize knowledge of the Abuse policy. A Quality Assurance audit was completed on 10/6/10 consisting of interviews with interviewable residents residing in the facility about abuse, including questions specific to involuntary seclusion. The interview included education on reporting of abuse.	F 223		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT	F 225		11/3/11

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F 225	Continued From page 7 ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		

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F 225	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to immediately report to the Administrator an allegation of abuse involving involuntary seclusion and verbal abuse for 2 of 2 allegations reviewed. The allegations involved 3 sampled residents(R21,R17,R19) in a sample of 27. Findings include: 1. The facility letter titled "Resident Abuse" dated 9/24/11 states, "[Z4, Head of Staffing Agency] reported.....that her staff[Z2,Licensed Practical Nurse,LPN and Z3, Registered Nurse, RN] told her that back on 9/12/10, [E12, Certified Nurse Aide, CNA] placed lifts in front of the room and bathroom doors to [R21's] room to block him in the room.....[E12] was in today and stated he was the only person on the hall that night, 'the other CNA was on break, and I needed to do my bed checks.'.....According to another CNA[E13], [E12] blocked the room door with the sit to stand lift and when she[E13] saw the door was closed [E13] knocked on the door and tried to open it. [E13] could not push the door open and went in through the next room to enter through bathroom door. That door was blocked with a [mechanical] lift. When [E13] entered the room, [R21] and his roommate[R17] were both awake, up and walking in the room....." E2, DON, stated 9/29/11 at 1:00pm that the involuntary seclusion of R21 and R17 by E12, CNA occurred on 9/12/10 at 3:00am and was not reported to herself or E49, former Administrator until 9/23/10. E2 confirmed that E12 was not suspended until 9/23/10. E2 stated that Z2 and	F 225		

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F 225	Continued From page 9 Z3 thought that the E45, RN had reported the involuntary seclusion to the Administrator. The undated statement written by E45, RN states that she thought Z3 would be reporting the involuntary seclusion, since she had initiated the "corrective action" with E12. The facility Time Detail Report dated from 9/11/10 to 9/24/10 documents that E12 completed his shift on 9/12/10(2:29pm-6:52am). E12 also worked the following shifts: 9/17/10(2:29pm-6:52am) ; 9/18/10(10:30pm-6:47am) and 9/19/10(2:32pm-6:58am). 2. The letter dated 6/30/11 states it was reported on 6/29/11 to "facility managers" that E10, CNA, made "inappropriate comments" to R19 during cares. The statement dated 6/30/11, written by Z6, Laboratory Phlebotomist, states that E10 was helping to hold R19 while blood was being drawn and told R19, "I've had it, if you[R19] hit/kick me, I'm gonna hit/kick you back." E2, DON, stated on 9/28/11 at 2:20pm that the incident involving E10 and R19 occurred on 6/27/11 between 5:30-6:00am. E2 stated the allegation of verbal abuse was not reported to E49, former Administrator, until 6/29/11. E2 stated when she asked E50, RN, why she didn't report the incident when it happened(6/27/11), E50 told her she didn't think it was abuse. E2 confirmed that E10 finished working the rest of her shift.	F 225		

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F 225	Continued From page 10 The facility Abuse Policy dated 12/2009 states, "Employees .....must immediately report any suspected abuse or incidents of abuse to the Director of Nursing.....Any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator or Director of Nursing Services.....The Administrator or Director of Nursing Services must be immediately notified of suspected abuse or incidents of abuse, If such incidents occur.....after hours, the Administrator and Director of Nursing Services must be called at home or must be paged and informed of such incident."	F 225		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to operationalize the Abuse Policy as relates to collecting the Certified Nurse Aide's(CNA's) fingerprints within ten working days after signing the Authorization and Disclosure Form for the Fingerprint Fee Based Applicant Background Check for 4 of 21 CNA's. The facility failed to designate in the Abuse Policy that the Administrator is to be notified immediately of any allegations of abuse. These failures have the potential to affect any of the 180 facility residents. Findings include:	F 226		11/3/11

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F 226	Continued From page 11 1. An undated list of CNA"s with date of hire was provided by the facility on 9/28/11. The following CNA's were identified as employed by the facility on the following dates: E23 hired 6/6/11; E24 and E27 hired 9/6/11; E28 hired 11/22/10. E30, Director of Human Resources, stated on 10/4/11 at 10:35am that none of the CNA' s listed above have had their fingerprints collected within 10 days of signing the authorization and disclosure form for the fingerprint based fee applicant background check. E30 stated the form is included in the orientation packet and is signed by the CNA's when they are hired. E30 confirmed all the CNA's have been working as providers of direct resident care since hired by the facility without the background check being done or the results known. The facility Abuse Policy dated April 2008 states, "The Personal/Human Resources Director, or other designee, will conduct employment background checks, reference checks and criminal conviction checks(including fingerprinting as may be required by state law) on persons making application for employment with this facility. Such investigation will be initialed within two days of employment or offer of employment. According to E2, Director of Nursing on 10-4-11 at 1:30 p.m. E23, E24, E27, and E28 provided direct care on various shifts and units within the facility (first and second floors, and Special Care Alzheimer's Unit). 2. The facility Abuse Policy dated 12/2009 states, "Employees, facility consultants and /or Attending	F 226		

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F 226	Continued From page 12 Physicians must immediately report any suspected abuse or incidents of abuse to the Director of Nursing.....Any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator or Director of Nursing Services.....The Administrator or Director of Nursing Services must be immediately notified of suspected abuse or incidents of abuse, If such incidents occur.....after hours, the Administrator and Director of Nursing Services must be called at home or must be paged and informed of such incident." E1, Administrator, confirmed on 9/28/11 at approximately 2:30pm that the policy (erroneously) states staff must immediately report allegations of abuse to either the Administrator or the Director of Nurse, instead of only reporting allegations immediately to the Administrator. The Centers for Medicare & Medicaid Services (CMS) 672 form completed by the facility on 9-26-11 states there are 180 residents living in the facility.	F 226		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 312		11/3/11

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interview the facility staff failed to verbally cue R17, with swallow dysfunction, to follow safe swallow guidelines per assessment and care plan to prevent aspiration. R17 is one of 27 sampled residents.

The findings include:

The September 2011 Physician Order Sheet (POS) documents R17 has diagnoses which includes Vascular Dementia, and Pharyngeal Dysphagia. The quarterly Minimum Data Set (MDS) dated 8/07/11 identifies R17 with severe cognitive impairment, and requires supervision and cueing for eating.

R17's Speech Evaluation dated 9/22/10 documents "Patient seen for VFSS (Videoflorecent Swallow Study- patient with severely delayed swallow, silent penetration with thin and nectar liquids, weak cough unable to clear. R17's diet order recommendation for Pureed Food with honey thickened liquids by teaspoon only. Standard aspiration precautions , direct supervision of meals, and verbal cues to swallow during meals."

R17 had posted Swallow Precautions posted on the wall over his bed dated 9/25/10 which stated "Total assist with all meals , alternate food and fluids, small bites, Take liquid by spoon only, no ice cream, sherbet, and verbal cues to swallow."

R17's tray diet slip lists General Pureed diet with Honey Thick Liquids. Directions to staff listed on the tray slip included "total assist for feeding ,give honey thick liquids by spoon only, alt. (alternate) bite of food then teaspoon of liquid, nothing that

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F 312	Continued From page 14 melats into a thin liquid, verbaly cue pt (patient) to swallow food/liquids." On 9/26/11 at 12:30 pm Certified Nurse Aide (CNA) E36 brought R17 his lunch tray with five bowls of pureed food with lids and glasses of honey thick milk, red juice, and orange juice. R17 was seated at the table waiting, he immediately started feeding himself multiple bites of food in rapid succession. R17 took dozens of bites of food, before taking any liquid. The spoon was often heaped with food. CNA E36 and E37 were seated at the table with R17 and three other residents. Neither CNA prompted R17 to alternate bites of liquids and solids. E36 occassionally prompted R17 to slow down. At the beginning of the meal R17 was using his spoon to consume the thickened milk , at 12:45 pm, R17 picked up the glass of milk and started drinking out of the glass, tipping the cup up with his chin pointing to the ceiling. Neither CNA prompted R17 to use his spoon to drink the milk until he was down to the bottom of the glass, when E37 stated "Use your spoon it will make it easier to get out". R17 then started using his spoon until done with the milk. At 1:00 pm R17 picked up his glass of thickened orange juice and started drinking out of the glass tipping it upward. R17 drank 75% of the juice out of the glass with no prompting from the staff to use his spoon. R17 started clearing his throat and was coughing. E36 prompted him to "slow down". R17 continued to drink his cranberry juice directly out of the cup, still clearing his throat and coughing slightly. Staff did not prompt R17 to use his spoon. At 1:15 pm R17 left the table with staff assistance. R17's diet slip was on the table and it did have the swallow precaution instruction clearly printed on the diet	F 312		

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slip.

On 9/27/11 at 12:30 pm R17 was seated at the dining room table waiting for lunch. R17 kept saying "Hungry!". At 12:42 pm Nurse E38 brought R17's meal with pureed food but no drinks. R17 started feeding himself large spoonsful of pureed food in rapid succession. There were no staff seated at the table with him for the first few minutes of the meal. At 12:45 pm E38 brought the thickened drinks to the table. R17 had consumed 15 bites of pureed food before the drinks arrived. R17 picked up the glass of thickened apple juice and started drinking out of the cup tipping his chin and glass upward. R17 was clearing his throat and coughing intermittently, CNA E37 and E41 were at the table assisting other residents at the table. They did not prompt R17 to use his spoon to drink the orange juice. At 1:00 pm R17 was using his spoon to consume his thickened milk. CNA E37 said to R17, "(R17), Don't you want to drink from your cup?". R17 replied "No" and continued eating with his spoon. R17 was taking large spoonsfuls of pureed bread, R17 consumed the bowls of bread in three bites. R17 then started to drink a glass of thickened cranberry juice, this time E42 did prompt R17 to use his spoon, which he did for a short time. At 1:15pm R17 was coughing and making gurgling noises while drinking out of his glass. E42 prompted R17 to take slow sips but did not prompt R17 to use his spoon.

On 9/28/11 at 9:30 am Speech Therapist E43 confirmed that the 9/10 swallow precautions are still in effect for R17, which include small bites, small sips, alternating bites of food and sips of

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F 312	Continued From page 16 liquids. E43 stated that R17 is at high risk for aspiration. The staff should be cueing R17 to use the spoon for liquids. E43 stated that R17 will stuff his mouth with food , alternating bites of food and fluids and using the spoon with slow him down enough to give him a chance to swallow between bites. E43 stated although he is not a total assist anymore staff should be sitting with him to verbally cue him during the meal.	F 312		
F 314 SS=D	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 and interview the facility failed to use preventative skin care measures for one of 4 residents (R13) on the sample of 27 with skin breakdown. Finding include: On 9/29/11 at 11:35am, R13 talked about how sore his bottom was getting from sitting so much. R13 stated on 9/29/11 at 11:35am, that he told the nurse on the unit at 8:00am that he needed his special cream for his buttocks and coccyx area because it is very sore. R13 stated the	F 314		11/3/11

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F 314	Continued From page 17 nurse said he would have to wait because she was very busy, but at 11:35am no one had come to apply the cream. R13 also stated that sometimes it can go 2 or 3 days without getting the cream applied. On 9/12/11 the skin assessment reflects that R13 was assessed at high skin risk. On 9/29/11 at 11:35am, R13's both inner buttocks were fiery red along with the scrotal area, and with E35, Assistant Director of Nursing present stated there was an open area that staff were not aware of on the coccyx. R13 voiced being upset that he had been healed of skin openings and now he said he is going backwards. On 9/28/11 at 1:30pm R13 had an open wound on his left foot with a wound vac (vacuum) in place. R13 stated on 9/29/11 at 11:35am that he is nonambulatory requiring assist for ambulation, because of not being able to put any weight on the left foot.	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 322		11/3/11

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F 322	Continued From page 18 Dietitian failed to notify the Physician of potential fluid volume overload and possible need to change water flushes for one (R18) of three residents reviewed for G-(gastrostomy)Tube feedings in the total sample of 27. Findings include: R18 ' s History and Physical dated 08/19/11 documents a diagnosis of Dehydration. The Consultation Report of 08/19/11 documents a history of Congestive Heart Failure (CHF). R18 ' s Care Plan dated 08/22/11 documents " Potential for fluid volume deficit related to diuretic use, NPO (nothing by mouth) status with G-Tube for feedings and flushes, dysphagia, " and " G-Tube feedings and flushes as ordered. " The Physician ' s Order Sheet dated 9/11/11 document the following G-Tube water flush orders: "Give 130cc (cubic centimeters) per H20 (water) flush per G-Tube every 4 hours. Flush 50cc before and after medication pass per G-Tube. 50cc H2O flushes before and after medications and boluses. 150cc H2O flush every shift." E7, Registered Dietitian (RD) stated she did not review residents ' intake and output records when doing monthly assessments for residents receiving tube feedings. E7 stated she was unaware that documentation in the Medication Administation Record (MAR) reported R18 was receiving more free water than she had recommended in her Enteral Nutrition Progress Notes dated 09/12/11. E7 failed to address the potential fluid volume overload and possible need to decrease the frequency and volume of G-Tube water flushes. According to the 09/01/11 to 09/30/11 MAR, R18 received 2344cc intake every 24 hours. in the Enteral Nutrition Progress Notes dated 09/12/11	F 322		

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F 322	Continued From page 19 E7 had recommended a 24 hour intake of 1814 cc every 24 hours. Fluid intatke documentation reflects that R18 received 513cc more fluids per day than R7 recommended.	F 322		
F 323 SS=H	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. This REQUIREMENT is not met as evidenced by: A. Based on observation, interview and record review the facility failed to follow facility policy or the plan of care in the transferring or the supervision of the following residents: R5, R4, R3, and R2. The failure of the facility resulted in serious injury to each of these residents. R5, R4, R3, and R2 are four of fourteen residents sampled for falls and fractures. The particular failures are as follows: The facility failed to provide immediate attention per the plan of care to R5 one of 14 residents sampled for falls and fractures. R5 had exhibited behaviors of non-compliance and self transfer when she refused immediate attention. As a result R5 attempted to transfer herself to bed and fell. This fall resulted in a fracture of the right leg. The fracture succeeded to a gangranous infection that shortly necessitated a below the knee amputation of the right leg.	F 323		11/3/11

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F 323	Continued From page 20 The facility failed to have two staff in attendance when bathing R4. R4 was a resident who required total care and the assistance of two while bathing. R4 (who requires total care and the assist of two while bathing) was being showered with the assistance of one Certified Nursing Assistant (CNA). The CNA turned away from R4 and R4 fell from the shower chair striking his head on the floor. This required hospitalization and stitches to close the wound in R4's head. The facility failed to assess for an adequate posture device to ensure R3 could not fall from his wheelchair. R3 is a resident who is confined to a "special" wheelchair when out of bed. R3 has diagnoses that affect his posture and the safety with which he sits in the wheelchair. R3 has poor safety awareness and was able to remove his own seatbelt. R3 sustained a fall from the wheelchair that resulted in a fractured hip. The seat belt that was supposed to keep R3 in his chair was not fastened at the time R3 had the fall. The facility failed to use two staff to assist in a mechanical lift transfer of R2. R2 is a resident who requires total assist with a mechanical lift for transfer. The facility policy requires two staff members to be in attendance with a mechanical lift. R2 was being transferred with the mechanical lift by a single CNA. As a result R2 was dropped from the lift and suffered a head injury that required stitches to the back of the head. Findings include: 1) The September 2011 Physician's Orders	F 323		

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indicate R5 has diagnoses of Multiinfarct Dementia, Neurogenic Bladder and Paraplegia. The December 2010 Minimum Data Set documents R5 is cognitively impaired, is not ambulatory, is an extensive two person transfer, and is incontinent of both bowel and bladder. The falls assessment and care plan dated December of 2010 shows R5 is a high fall risk with a previous fall.

A 12/14/10 "Occurrence Report" shows R5 had attempted to self transfer and sustained a fall. The report states, "...Root cause: pt. (patient) self transfer on slide board without supervision, (and) lose balance r/t (related to) decrease muscle strength..."

The care plan dated December of 2010 states, "...can be inpatient at times. Does not always want to wait for help/assistance..."

Z1, R3's daughter stated on 9/27/11 at 11:00 AM that she had informed the facility by way of E2 Director of Nursing, that her mother was mentally deteriorating and that she would not listen when told she would have to wait. She stated, "...I told them in December (2010) she would not wait to be laid down - that she would try to lay herself down..."

The Director of Nurses (DON) stated on 9/28/2011 at 10:00 AM, "...yes, she would try to self transfer. She would not wait for help after she asked for it - I told all the staff to lay her down as soon as she asks..."

E3 CNA stated on 9/27/2011 at 2:25 PM that R5 had asked her to be put to bed after supper on

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3/16/2011. E3 stated, "...I had heard she (R5) would try to transfer herself if she was not laid down right away. I don't think we have enough staff to safely care for the residents with the staffing we have now..."

E5 CNA stated on 9/28/2011 at 3:00 PM, "...I was part - time taking care of (R5). She tried to transfer herself the night before (she fell). We do not have enough staff to provide safe care. We have five or six people that require two assist to lay down..."

E4, Registered Nurse (RN) on 9/27/2011 at 4:00 PM stated, "... She (R5) had come out of her room 3 times(the evening of 3/16/2011) asking (me) to go to bed. I told the CNA's (E3 and E5) myself. They were working with another resident. They said they would be right there. Then (R5) came out one more time and asked to be put to bed...I knew she had a fall history but I did not know about her behavior of self-transfer. I didn't know she would do it that fast..."

The "Occurrence Report" dated 3/16/2011 reads as follows: "...Resident requested to be put to bed x (times) 3 over the course of 10-15 minutes and was reassured that the CNA's (Certified Nursing Assistants) would do this next for her after they were done with previous task. Resident was then found on floor with distressed look on face asking for help..."

Nurses notes dated 3/18/2011 (no time recorded) states "...Night nurse passed on concern for pt (patient)...I looked at pt. and saw discolored areas on her Rt. (right) foot white bands across top and blackened areas on toes. Rt. leg was

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F 323	Continued From page 23 lying on lateral side and thigh was swollen...I called and (was) instructed to call (doctor) and send her to ED (emergency department) ASAP (as soon as possible)...Pt. later reported to have broken right femur..." The Consult Notes dated 3/21/11 through 3/28/11 reads as follows: "...Assessment: 1. Right distal femur comminuted bicondylar (possible intercondylar) femur fracture. 2. Right medial tibial plateau fracture with compression and step-off. 3. Comminuted distal third fibula/tibial fractures with angulation , right...9. Possible gangrene, right little toe...Plan: 3...Due to the right foot wound, compromised circulation and severe bone demineralization, we do not feel that hardware can be anchored to stabilize the lower leg fractures and due to the presence of the wounds and impaired circulation it is felt that the leg is not salvageable and would most likely require below vs (versus) above the knee amputation..." R3 was eating lunch with her daughter on 9/27/11 at 12:30 PM. R3 was in a wheelchair at the table with a right below the knee amputation. 2.) The June 2011 Physician's Orders document R4 has diagnoses of Severe Dementia and Right Sided Weakness. The most recent Minimum Data Set (MDS) dated April of 2011 indicates R4 is total assist for all activities of daily living. The MDS shows R4 is a total 2 person assist for hygiene/bathing. The MDS indicates R4 is not steady in a surface to surface transfer and is only able to stabilize with assistance. The "Occurrence Report" dated 6/01/11	F 323		

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documents R4 was being showered by E9 CNA alone when he (R4) fell from the shower chair and sustained a head laceration that required stitches to close. The report states, "...Notified by CNA res fall in shower room. Assess contusion to (right) forehead...Also, 2 cm (centimeter) skin tear to (right) forehead...Resident sent to (Emergency Department)...Resident received sutures to right forehead area... The statement written by E9 states, "...took resident to shower room to give shower. I turned to turn the water on and resident leaned forward and as I turned back around the shower chair was off the ground and he fell out of chair on the floor and hit his head..."

E2 DON stated on 9/29/2011 at 3:00 PM that the policy of the facility is that two staff are to give showers/baths to residents.

3.) The September 2011 Physician's Orders documents R3 has diagnoses of Neurosyphilis, Schizophrenia, Mild Mental Retardation, Dementia, and Paranoia. The 8/14/11 assessment shows R3 is a high risk for falls. The June 2011 Minimum Data Set documents R3 is cognitively impaired, is a two person extensive assist for transfers, is incontinent of bowel and bladder, is not ambulatory and is extensive to total assist for all other activities of daily living.

The Occupational Therapy notes dated 2/3/09 to 2/17/09 states, "...My suggestion is that we make sure that he is all the way back into his seating system and that we use some type of seat belt to make sure that he maintains the position..."

Z7, Director of Therapy stated on 9/28/11 at 11:00 AM that "...yes, I know who (R3) is - he was

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assessed as needing a seat belt to maintain his posture. He would be unsafe to sit in the wheelchair without a positioning device. He has poor safety awareness..."

The March 30, 2011 Physical Therapy Evaluation and Plan of Treatment states, "...Range of Motion (ROM) (lower extremities) (right lower extremity) Impaired (75 degree contracture at B(Both) knees, patient has had contractures for years per nursing staff. Increased spasticity. Unable to extend knees passively or extend hips past 20 (degrees) flexion...LLE ROM (left lower extremity range of motion) = impaired...increased spasticity..."

The Care Plan dated 7/7/2011 states, "...seat belt on when up in w/c (wheelchair)..."

The Fall Investigation Report dated 8/7/11 reads as follows "...CNA called (nurse) at 3:30 PM to look upon the resident, he (R3) was on the floor..." The report documents "Staff did not follow plan ? Seat belt off..."

On 9/28/2011 at 9:30 AM Director of Nursing stated, "...res could remove (unfasten) seat belt. He has done so before on numerous occasions, espescially when he sees the (mechanical lift) because he is trying to help. (R3) has never tried to transfer himself but he does have diagnoses that makes his posture a problem..."

The report to the State Survey and Certification Agency Regional Office dated 8/9/2011 reads as follows: (R3) has been a resident since 11/4/09...On August 7th, 2011 (R3) fell out of his geri chair after he removed his safety belt...An

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F 323	Continued From page 26 x-ray was ordered for August 8th which determined (R3) had a left hip fracture. He was sent to emergency room for further evaluation. (R3) will be returning to (the facility) after his surgery. A new "alarming safety seat belt" will be in place when (R3) returns..." On 9/28/11 at 1:30 PM R3 was in his wheelchair. An attempt was made to interview R3. He did not readily respond to questions but did respond to a request for him to unfasten his safety belt. There was no sound when the belt was unfastened that signified the alarm was working. A request was then made that a staff member, E38, Licensed Practical Nurse who had entered the room, try the seat belt. Again the alarm did not sound. After examining the alarm and pushing some buttons the alarm sounded. E38 stated the alarm was not turned on. 4. The October 2011 Physician's Orders documents R2 has diagnoses of Urinary Tract Infection and Dehydration.The June 2011 MDS (Minimum Data Set) indicates R2 is an extensive to total assist for all activities of daily living. The MDS shows R2 is a total 2 person assist for transfers. The 6/15/11 assessment rates R2 as a high fall risk. The 8/14/11 "Fall Investigation - Nursing Home - Internal Report reads as follows: Describe the incident: Res (resident) was in process of transfer per (mechnical sling lift) (and) fell... Injury Type: Head Trauma... Witness statement regarding occurrence: I (CNA E55) went into his room to get him up. I put the sling under him and went into the hall to ask a CNA to help me. She said she will be there in a min (minute) so I went in hooked the sling up and lifted him (R2) just a little...Follow - up comments:	F 323		

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F 323	Continued From page 27 Root cause - poor transfer technique body shifted in sling when lifted. Intervention - staff education and discipline..." The nurses notes dated 8/14/11 at 4:30 PM states the resident was non-responsive after the fall with fixed pupils non-reactive to light. The notes state R2 was transferred to the hospital with a laceration on the back of his head. The Care Plan dated 6/15/11 states, "...(mechanical lift) (with) 2 assists..." The Physician's Orders dated October 2011 show another resident R1 is a total 2 person assist with transfer. The Care Plan dated 6/16/11 states, "...Assistive Devices as ordered - use (mechanical lift) for all transfers...(mechanical lift (with) 2 assist..." R1 identifed by the facility as an interviewable resident and selected for an individual interview stated on 9/27/2011 at 10:30 AM, "...Sometimes when they transfer me with the lift only one person comes in...This morning when I was transferred (at 6:00 AM), I was transferred by one person..." The DON stated on 9/29/11 at 1:00 PM the staff members who transferred R1 and R2 admitted that they transferred R1 and R2 by theirselves. The DON stated that both staff members were terminated for their failure to follow facility policy regarding mechanical transfers. B. Based on observation, record review, and interview, the facility failed to provide a safe environment and appropriately supervise one of 11 sampled cognitively impaired residents, out of a sample of 27, by having the electrical cord to the bed plugged into the wall beside and within reach of the resident (R26), resulting in R26 putting the cord around her neck, and attempting	F 323		

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F 323	Continued From page 28 to put her fingers into the same electrical socket. Findings include: According to admission records and the POS (Physician's Order Sheet) for 8/11, R26 was admitted on 8/10/11 with multiple diagnoses including Dementia, Debility, Bradycardia with Syncopal episode, and Memory Loss. The Geriatric Rounding Service Note by the Nurse Practitioner on 8/19/11 also added "anorexia and dehydration. . .appetite very poor. . . .refusing to eat. . . .refuses IV (intravenous) fluids. . . .more confused than normal. . . ." The MDS (Minimum Data Set) of 8/19/11 assesses R26 as moderately cognitively impaired, has verbal behaviors, and requires assistance for ADLs (activities of daily living). According to the Occurrence Report dated 8/23/11, at 7:10am, R26 was found with the "black plug-in cord wrapped around her neck. Cord was not tight. Small amount of emesis was noted on pillow. . . .no red marks. . . " The family was notified and they declined to send R26 to the hospital. A progress note dated 8/23/11 states that a psychological assessment was attempted but "pt (patient) declined services." E39 (day nurse) stated on 9/28/11 that R26 had been asleep when found, and there had been no evidence or verbalizations of suicidal ideations. E39 stated that R26 had been declining and was "just confused." E39 demonstrated how the bed was set up and where the outlet and plug were. The bed was set with the side of the bed next to the wall (parallel), so the outlet was approximately 18 inches above	F 323		

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F 323	Continued From page 29 the mattress toward the head of the bed, within easy arm reach of a resident in the bed. E39 stated they removed the plug and plugged the bed into another outlet. E39 also stated that they placed plastic outlet protector plugs. E39 stated they had talked about moving the bed the other way (perpendicular to the wall), but they did not move the bed into a different position at that time. Also, E41 (evening nurse) made a written statement that she observed R26 attempting to "put her fingers in the light socket. . . . don't recall seeing plastic protector in outlet. . ." E41 also stated that she lowered the bed and moved the bed "away from the wall so she couldn't reach it." At 5:30pm on 8/23/11, the Physician Communication and Progress Note by E41 states that R26 "continued to become increasingly confused. . . .would continue these behaviors (fingers in light socket) shortly after being redirected. . . .unable to get IV fluids into her due to the continued taking out of the IVs. . . .also refusing to eat/drink anything. . . ." R26 was then sent to the hospital, where R26 was admitted with confusion, tachycardia, UTI (urinary tract infection), and lactic acidosis, according to the Emergency Department Initial Milestone.	F 323		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363		11/3/11

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F 363	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to serve double portions of food for two sampled residents on Pureed diets, (R17 and R2). R17 and R2 are two of 27 sampled residents. This failure has the potential to affect six other residents who are to receive double portions including R39, R40, R41, R42, R43, and R44. The findings include: R17's September 2011 Physician's Orders list diagnoses which includes Vascular Dementia, and Dysphagia. R17 had diet orders for General Pureed Diet with Honey thick liquids. A Diet Communication request dated 8/24/11 states " Add extra on (R17's) tray. He always asks for food and days he is hungry especially at night". R17's Diet tray slip documents "General Pureed Honey Thick Liquids, Double Portions, Double Everything". R17's annual Minimum Data Set (MDS) dated 2/23/11 lists R17 as 68 inches tall and 151 pounds. The quarterly MDS dated 8/07/11 lists R17's weight at 141 pounds. R17's 9/13/11 weight was 148 pounds. R2's September 2011 Physician Order Sheet lists a diet order for General Pureed, No Added Salt, Honey Thick Liquid. R2's Diet tray slip lists the same diet and also lists "Double Portions." R2's 2011 weight monitoring record shows slow weight loss over last 6 months listed May-231.8 pounds, June 225 pounds, July-224.8 pounds, and August 2011 weight at 220 pounds.	F 363		

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F 363	Continued From page 31 On 9/27/11 at 12:20 pm the tray line was observed during serving. The menu planned for residents on Pureed diets to receive a #6 (2/3 cup)portion of Italian Meatloaf, a #8 (1/2 cup)portion of Augratin Potatoes, a #10 (2/5 cup) serving of wax beans, a #16 (1/4 cup) portion of pureed bread and margarine and a #10 portion of Strawberry Shortcake. The residents with Pureed Diets were served one portion of each entree including R17 and R2 who's diet slips listed "Double Portions" for each meal. The Dietary Manager E46 was at the tray line and was assisting to dip up portion of food for the pureed diets. The diet staff assembling the tray with silverware, etc would call the diet to the Cook , and Dietary Manager "Need 4 purees". The diet aide did not state the resident's names with the request. When R17 and R2's trays were served, the server was looking at the diet slip but did not call for double portions. On 9/27/11 at 12:30 pm R17 and R2 were seated at the dining room table but had not been served yet. R17 was repeated saying "Hungry!" while he was waiting. R17 received his tray at 12:42pm and R2 received his tray. R17 fed himself consuming 100 percent of his meal. At 1:15 pm R17 said "Hungry!" CNA E42 asked R17 if he wanted more food and R17 said "Yes!". E42 brought R17 more drinks and stated she would call to the kitchen for more food. At 1:20 pm ,R17 said he was done and was assisted out of the dining room at 1:20 pm, additional food had not arrived from the kitchen. On 9/27/11 at 12:30 pm R2 was fed by Certified Nurse Aide (CNA) E42. R2 consumed 100	F 363		

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F 363	Continued From page 32 percent of his food, except for the pureed fruit and bread that were in plastic cups with lids that were not opened. On 9/27/11 at 3:45 pm Dietary Manager E46 stated that R17 and R2 were to receive double portions. E46 stated the staff do put both portions in a single bowl. E46 was reminded that during the observation of serving only one portion of Pureed food was put in each bowl and the staff were not specifying double portions for anyone during the tray line. E46 did confirm that this was correct. Registered Dietician E48 stated on 10/01/11 that they have eight residents with double portions listed on their diet tray cards. E48 provided a computer listing of residents with dietary careplans for double portions for all meals: R2, R17, R39,R40,R41,R42, R43 and R44.	F 363		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to monitor potentially	F 371		11/3/11

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F 371	Continued From page 33 hazardous food cooling temperatures to ensure that food was rapidly cooled to 41 degrees Fahrenheit (F.) or below within 6 hours to prevent bacterial growth and subsequent foodborne illness. This has the potential to affect all 180 residents in the facility. The findings include: The "Week at a Glance" menu showed that Pot Roast was planned on the menu for 9/28/11 lunch meal for all diets. On 9/27/11 at 10:15 am a large foil covered pan of Roast Beef was stored on the bottom shelf of the walk-in cooler in the Dietary Department. The internal temperature of the walk-in cooler was 40 degrees F. per interior hanging thermometer and the outside temperature dial read 39 degrees F. The label on the foil said "Roast Beef 9/26/11 6:15 p (p.m.) use by 9/28/11" There was no temperature information documented on the label. The foil on the pan was not vented. When the foil was removed, there were four, eight inch thick chunks of cooked roast beef in the pan. The internal temperature of each chunk of roast beef measured 44 degrees F with surveyor's thermometer. Dietary Manager E46 also checked the temperature of the roast beef with her thermometer which also registered 44 degrees F. E46 stated that this was 20 pounds of roast beef. Each quarter was approximately 5 pounds. E46 stated that they do not have a cooling log or documentation of temperature monitoring. Z5, Contracted Dietary Supervisor stated on 9/27/11at 10:30 am, the roast beef was cooked	F 371		

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F 371	Continued From page 34 on 9/26/11 in the evening and was it was vented for two hours to cool in the walk-in cooler and then was covered at 8:00 pm before they went home. Z5 stated they took the temperature of the roast when it came out of the oven, but they do not have any documentation of this and there was no one in the dietary department after 8:00 pm to check to ensure the roast had cooled to 41degrees F. or below . On 9/27/11 at 4:40 pm Z5 stated he had spoken to the night cook who stated the roast was 165 degrees F. when it went into the walk-in. Z5 stated the cook said he checked the temperture before he left but he did not say what the temperature was, and confirmed that there was no monitoring to ensure that the initial 2 hour and four hour checks were completed to ensure proper cooling. This potentially hazardous food remained in the danger zone for 16 hours without the aid of rapid cooling measures. The facility policy dated 4/2010 documents "Methods of cooling for beef roasts, turkey, pork loin, pork shoulder are as follows: 1. Check internal temperature; ensure that it is at proper temperature according to recipe. 2.Remove from oven and cut into smaller portions of food.....4. Cover each pan with aluminum foil , pull back right corner, approximately 4 inches...6. Each smaller portion needs to meet 40 degrees or below within 4 hour mark...7. Check the temperature after two hours; if the internal temperature has not reached 70 degrees F, notify manager. 8. If at the 2 hour mark , the temperature is at 70 or less, cover items completely with foil and date. 9. At the 4 hour mark checkthat the temperature had met 40 degrees."	F 371		

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F 371	Continued From page 35 The Centers for Medicare & Medicaid Services (CMS) 672 form completed by the facility on 9-26-11 states there are 180 residents living in the facility.	F 371		
F 441 SS=E	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.	F 441		11/3/11

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F 441	Continued From page 36 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: A. Based on observation, interview, and record review facility staff failed to wear gown and gloves when providing care to one resident (R14) in the sample of 27. Findings include: The Physician Order Sheet dated 09/16/11 reports R14 ' s diagnoses as Clostridium Difficile (C. Diff) and Methicillin Resistant Staphylococcus Aureus (MRSA). R14's plan of care specifies that R14 is on contact precautions. On 09/27/11 at 4:05pm E8, Certified Nurse Aide (CNA) entered R14 ' s room and provided care to R14 without donning gown and gloves. After providing care for R14, E8 entered R28 ' s room to provide care. On 09/27/11 at 4:20pm E8 confirmed he did not wear gown and gloves when assisting R14. R8 stated he did not know that R14 was in contact isolation. The facility ' s Infection Control Policy and Procedure Manual for Contact Precautions includes wearing a gown for " all interactions with a resident that may involve contact with the resident or potentially contaminated items in the resident ' s environment, " and " Gloves must be worn when entering the room " (p.31). B. Based on observation, record review and interview the facility failed to utilize a disinfectant	F 441		

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F 441	Continued From page 37 for mopping floors in resident use areas, including in rooms under Isolation Precautions for MRSA and for C.Diff. for one sampled resident (R14) in a sample of 27 and two supplemental residents, (R34, and R45). The facility also failed to utilize a 1:10 chlorine bleach solution or equivalent to decontaminate floors for residents under precautions for C. diff. (R14). The findings include: On 9/26/11 at 10:00 am Housekeeper E52 was interviewed about how to complete isolation room cleaning. E52 stated that the rooms are cleaned with bleach wipes for areas that are touched by residents. E52 stated the floors in the bathroom are mopped with the green floor cleaner. E52 had just finished cleaning in R34's room. There was an isolation cabinet set up outside the door. On 9/26/11 at 11:30 am Housekeeper E53 stated that they use bleach wipes for cleaning isolation rooms for C. diff and for MRSA. The floors are mopped with the green floor cleaner. On 9/26/11 at 2:45 pm Houskeeper E54 cleaned R14's room. R14 was under isolation for C. diff. infection. E54 stated the everything would be cleaned with the bleach wipes except the green floor cleaner would be used for the floors. Housekeeping Supervisor E51 stated on 9/29/11at 9:30 am that they use the green floor cleaner for mopping floors in resident areas, even in the isolation rooms. E51 provided the Material Safety Data Sheet which listed the product type as floor cleaner. The chemical ingredients did not	F 441		

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F 441	Continued From page 38 include a disinfectant. E51 confirmed that they have not been using a disinfectant for the floors. The undated facility housekeeping policy entitled "Infection Control Rooms Checkoff List" which E51 stated is used for deep cleaning and isolation cleaning stated "You are required to use bleach wipes and /or 1:10 ratio of bleach and water solution as the primary chemical in completing this deep clean. Due to the fact the residents may have C-diff, Mrsa, VRE, etc. Bleach need to be used to ensure we are properly following the correct infection control procedures." The policy listed 27 steps including "18. Clean and disinfect floor".	F 441		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.615e) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police.	F9999		

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F9999	Continued From page 39 This requirement is not met, as evidenced by: Based on record review and interview, the facility failed to initiate criminal history background checks within 24 hours of admission for 8 of 10 new admissions reviewed for criminal background checks (R29, R30, R31, R32, R33, R34, R35, R36). R29-R36 are 8 supplemental residents. Findings include: Criminal history background check information for newly admitted residents shows the following, with the date of admission and date the background check was initiated: R29, admitted 9/19/11, background check 9/23/11 R30, admitted 9/22, background check 9/26 R31, admitted 9/20, background check 9/26 R32, admitted 9/24, background check 9/26 R33, admitted 9/18, background check 9/23 R34, admitted 9/19, background check 9/23 R35, admitted, 9/14, background check 9/23 R36, admitted, 9/2/11, background check 9/13/11 E30 (Human Resources) stated on 9/30/11 at 1:30pm thought she had 10 days to do background checks - the same as new staff. E47 (Admissions) stated on 10/3/11 at 9:30am that when she is notified of the admission she does the website checks and completes the Conviction Information Name Check Request. E47 then passes that information on to E30, who does the criminal background checks. E47 also stated that for a while they were not getting	F9999		

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F9999	Continued From page 40 results promptly because results were being sent to the previous Human Resource Director's email address, and E30 did not have access to it. (B) 300.7050 d) 300.7050 f) Section 300.7050 Staffing d) Nurses, CNAs (Certified Nurse Aides) and social service and activities staff who work on the unit at least 50 percent of the time that they work at the facility shall participate in a minimum of 12 additional hours of orientation within the first 45 days after employment, specifically related to the care of persons with Alzheimer's disease and other dementia. This orientation shall be defined in policies and procedures; shall be in form of classroom, return demonstration, and mentoring, and shall define to new staff the elements contained in Section 300/7050 (e)(1)-(10). f) Within 6 months after January 1, 2005, or within 6 month after hire, the facility administrator and director of nursing shall attend the orientation for staff who work on the unit at least 50 percent of the time in accordance with subsection (d). This requirement is not met, as evidenced by: Based on record review and interview, the facility's Director of Nursing failed to complete the 12 hour orientation in the care of persons with	F9999		

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F9999	Continued From page 41 Alzheimer's disease within six months after hire. This failure has the potential to affect all 29 residents residing on the Alzheimer's unit. Findings include: Records for staff orientation and continuing education for the Alzheimer's unit contained no record or evidence that E2 (Director of Nursing) had completed the initial 4 hours of dementia-specific orientation or the 12 additional hours of orientation related to care of persons with Alzheimer's and other dementia. E44 (Unit Director) stated on 9/29/11 at 9:15am that she has previously requested evidence from E2 that she had completed any orientation. E44 has also offered E2 the 12 hour program E44 uses for all staff on the unit. E44 stated that E2 has never attended the 12 hour program with E44. E2 stated on 9/29/11 at 10:20am that she thought she completed the 4 hour orientation when E2 first started at the facility, but she did not recall any post-test or certificate. E2 also confirmed that she has never done the 12 hour training because she "didn't know I was supposed to." E2 stated she has been in the Director of Nursing position since 7/2010. According to the resident list, 29 residents presently reside on Alzheimer's/Dementia unit. (B)	F9999		

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F9999	Continued From page 42 300.3240a) 300.3240b) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. Based on interview and record review the facility failed to ensure facility staff were trained in appropriate interventions for wandering residents, resulting in involuntary seclusion being used as an intervention to confine two sampled wandering residents to their room (R21,R17), in a sample of 27. Locked mechanical lifts were used to block the doors of the room and bathroom to prevent R21 and R17 from exiting their room. Both residents were unable to leave the blocked room entrances and were unreasonably restricted from being able to freely access surroundings outside of their room. This past noncompliance occurred from 9/12/10 to 10/6/10. Findings include: The facility letter titled "Resident Abuse" dated 9/24/11 states, "[Z4, Head of Staffing Agency] reported.....that her staff[Z2,Licensed Practical Nurse,LPN and Z3, Registered Nurse, RN] told	F9999		

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her that back on 9/12/10, [E12, Certified Nurse Aide, CNA] placed lifts in front of the room and bathroom doors to [R21's] room to block him in the room.....[E12] was in today and stated he was the only person on the hall that night, 'the other CNA was on break, and I needed to do my bed checks.'.....According to another CNA[E13], [E12] blocked the room door with the sit to stand lift and when she[E13] saw the door was closed [E13] knocked on the door and tried to open it. [E13] could not push the door open and went in through the next room to enter through bathroom door. That door was blocked with a [mechanical] lift. When [E13] entered the room, [R21] and his roommate[R17] were both awake, up and walking in the room....."

The undated statement written by E13, CNA, stated, "I was looking for help to transfer a resident....I was walking down the hall and noticed [R21's] door was closed, so I knocked on the door and tried to open, but couldn't, so I went to [adjoining] room, there was a [mechanical] lift locked and pushed up against the bathroom door, so [R21,R17 in the adjoining] room couldn't get out of the room. After moving that[the lift] I entered [R21's] room to find a sit to stand lift locked in front of residents[R21,R17] door. Both [R21,R17] were up and trying to get out....." The statement documents the incident occurred on 9/12/10 at 3:00am.

E13, CNA, stated on 9/29/11 at 11:20am that she went to the south hall to find someone to help her transfer another resident, but was unable to find anyone. E13 stated she saw the door to R21's room was shut, so she thought staff was in the room. E13 stated, "I couldn't get [R21's] door to

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open. I went into the next room-the [mechanical] lift was against the adjoining bathroom door. I moved the [mechanical] lift and got into [R21's] room. [R21 and R17] were both up. The sit to stand lift was in front of the [room] door-it was locked in place."

The documentation of an interview of E12, CNA by E2, Director of Nursing(DON) dated 9/28/10 states, "I think it was 2:00am, [E11,CNA] was on break....No one was able to watch [R21], so I put the stand lift in front of the door-just the room door. I did this so I could do my bed check....." E12 stated on 9/29/11 at 11:25am that he does not remember anything about the incident(9/12/10).

The undated statement written by E45, RN states, ".....[E12] said all the CNA's were gone and [R21] was being aggressive and trying to get out of his room-he[E12] said he was trying to keep [R21] safe, so he was trying to figure out what he could do to take care of [R21] and all the other residents, so [E12] put a lift in front of the door.....I know [R21] was up quite a bit that nt[night]- going up and down the hall and kept going to the DR[dining room]....When the other nurse told [E12] that was the wrong thing to do, [E12] seemed very remorseful-didn't realize it was wrong, just wanted [R21] to be safe....."

E11, CNA, stated on 9/29/11 at 11:25am she was on break when the incident(9/12/10) occurred. E11 stated that R21 can be very violent and has punched other residents, but got along well with R17. E11 stated that "normally someone just stayed with [R21], light duty staff did a one to one with [R21], but that night[9/12] it was just [E12]

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and I on the hall...so we had to monitor [R21] as well as take care of [other] residents." E11 stated there were 30 other residents residing on the hall. When asked if E12 had barricaded R21 in the room any other time, E11 stated, "I believe it happened[involuntary seclusion] one other time and then [E12] was suspended. I heard it from the nurse's again, after the last incident he[E12] was suspended." E11 was unable to recall what nurse told her about the involuntary seclusion happening again.

Z3, Agency RN, stated on 9/29/11 at 11:00am stated they had a long discussion about involuntary seclusion with staff that night(9/12/10) and "don't do that because [R21] roams." Z3 stated that "[E12] thought he did nothing wrong." Z3 stated she was not aware of the involuntary seclusion occurring any other time.

E2, DON, stated on 9/29/11 at 1:00pm that she was unaware of the involuntary seclusion occurring anytime except the one time on 9/12/10. E2 stated, "I remember he[E12] believed he was trying to keep [R21] safe and did not see it as abuse." E2 confirmed that E12 was terminated for the involuntary seclusion of R21 and R17.

The Physician's Order Sheet(POS) dated September 2011 states R21 has a diagnosis of Dementia with Behaviors. The Minimum Data Set(MDS) dated 7/30/10 states R21 has cognitive and memory problems, resists care and is independent with ambulation/transfers. The September 2010 Behavior Tracking Form documents behaviors of anger, physical and verbal aggression.

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F9999	Continued From page 46 The POS dated September 2011 states R17 has a diagnosis of Dementia. The MDS dated 9/15/10 states R17 has cognitive impairment, behaviors of wandering, anger, resisting care and requires supervision for ambulation. The facility took the following measures to correct the non-compliance: All staff was re-educated on the Abuse policy. A Quality Assurance audit was completed on 10/6/10 for all nursing employees, consisting of employees being able to verbalize knowledge of the Abuse policy. A Quality Assurance audit was completed on 10/6/10 consisting of interviews with interviewable residents residing in the facility about abuse, including questions specific to involuntary seclusion. The interview included education on reporting of abuse. (B) 300.1210b)5) 300.1210d)6) 300.3240a) 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	F9999		

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F9999	Continued From page 47 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 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 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. A. Based on observation, interview and record review the facility failed to follow facility policy or the plan of care in the transferring or the supervision of the following residents: R5, R4,	F9999		

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R3, and R2. The failure of the facility resulted in serious injury to each of these residents. R5, R4, R3, and R2 are four of fourteen residents sampled for falls and fractures. The particular failures are as follows:

The facility failed to provide immediate attention per the plan of care to R5 one of 14 residents sampled for falls and fractures. R5 had exhibited behaviors of non-compliance and self transfer when she refused immediate attention. As a result R5 attempted to transfer herself to bed and fell. This fall resulted in a fracture of the right leg. The fracture succeeded to a gangranous infection that shortly necessitated a below the knee amputation of the right leg.

The facility failed to have two staff in attendance when bathing R4. R4 was a resident who required total care and the assistance of two while bathing. R4 (who requires total care and the assist of two while bathing) was being showered with the assistance of one Certified Nursing Assistant (CNA). The CNA turned away from R4 and R4 fell from the shower chair striking his head on the floor. This required hospitalization and stitches to close the wound in R4's head.

The facility failed to assess for an adequate posture device to ensure R3 could not fall from his wheelchair. R3 is a resident who is confined to a "special" wheelchair when out of bed. R3 has diagnoses that affect his posture and the safety with which he sits in the wheelchair. R3 has poor safety awareness and was able to remove his own seatbelt. R3 sustained a fall from the wheelchair that resulted in a fractured hip. The seat belt that was supposed to keep R3 in his

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F9999	Continued From page 49 chair was not fastened at the time R3 had the fall. The facility failed to use two staff to assist in a mechanical lift transfer of R2. R2 is a resident who requires total assist with a mechanical lift for transfer. The facility policy requires two staff members to be in attendance with a mechanical lift. R2 was being transferred with the mechanical lift by a single CNA. As a result R2 was dropped from the lift and suffered a head injury that required stitches to the back of the head. Findings include: 1) The September 2011 Physician's Orders indicate R5 has diagnoses of Multiinfarct Dementia, Neurogenic Bladder and Paraplegia. The December 2010 Minimum Data Set documents R5 is cognitively impaired, is not ambulatory, is an extensive two person transfer, and is incontinent of both bowel and bladder. The falls assessment and care plan dated December of 2010 shows R5 is a high fall risk with a previous fall. A 12/14/10 "Occurrence Report" shows R5 had attempted to self transfer and sustained a fall. The report states, "...Root cause: pt. (patient) self transfer on slide board without supervision, (and) lose balance r/t (related to) decrease muscle strength..." The care plan dated December of 2010 states, "...can be inpatient at times. Does not always want to wait for help/assistance..." Z1, R3's daughter stated on 9/27/11 at 11:00 AM	F9999		

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that she had informed the facility by way of E2 Director of Nursing, that her mother was mentally deteriorating and that she would not listen when told she would have to wait. She stated, "...I told them in December (2010) she would not wait to be laid down - that she would try to lay herself down..."

The Director of Nurses (DON) stated on 9/28/2011 at 10:00 AM, "...yes, she would try to self transfer. She would not wait for help after she asked for it - I told all the staff to lay her down as soon as she asks..."

E3 CNA stated on 9/27/2011 at 2:25 PM that R5 had asked her to be put to bed after supper on 3/16/2011. E3 stated, "...I had heard she (R5) would try to transfer herself if she was not laid down right away. I don't think we have enough staff to safely care for the residents with the staffing we have now..."

E5 CNA stated on 9/28/2011 at 3:00 PM, "...I was part - time taking care of (R5). She tried to transfer herself the night before (she fell). We do not have enough staff to provide safe care. We have five or six people that require two assist to lay down..."

E4, Registered Nurse (RN) on 9/27/2011 at 4:00 PM stated, "... She (R5) had come out of her room 3 times(the evening of 3/16/2011) asking (me) to go to bed. I told the CNA's (E3 and E5) myself. They were working with another resident. They said they would be right there. Then (R5) came out one more time and asked to be put to bed...I knew she had a fall history but I did not know about her behavior of self-transfer. I didn't

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F9999	Continued From page 51 know she would do it that fast..." The "Occurrence Report" dated 3/16/2011 reads as follows: "...Resident requested to be put to bed x (times) 3 over the course of 10-15 minutes and was reassured that the CNA's (Certified Nursing Assistants) would do this next for her after they were done with previous task. Resident was then found on floor with distressed look on face asking for help..." Nurses notes dated 3/18/2011 (no time recorded) states "...Night nurse passed on concern for pt (patient)...I looked at pt. and saw discolored areas on her Rt. (right) foot white bands across top and blackened areas on toes. Rt. leg was lying on lateral side and thigh was swollen...I called and (was) instructed to call (doctor) and send her to ED (emergency department) ASAP (as soon as possible)...Pt. later reported to have broken right femur..." The Consult Notes dated 3/21/11 through 3/28/11 reads as follows: "...Assessment: 1. Right distal femur comminuted bicondylar (possible intercondylar) femur fracture. 2. Right medial tibial plateau fracture with compression and step-off. 3. Comminuted distal third fibula/tibial fractures with angulation , right...9. Possible gangrene, right little toe...Plan: 3...Due to the right foot wound, compromised circulation and severe bone demineralization, we do not feel that hardware can be anchored to stabilize the lower leg fractures and due to the presence of the wounds and impaired circulation it is felt that the leg is not salvageable and would most likely require below vs (versus) above the knee amputation..."	F9999		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 52 R3 was eating lunch with her daughter on 9/27/11 at 12:30 PM. R3 was in a wheelchair at the table with a right below the knee amputation. 2.) The June 2011 Physician's Orders document R4 has diagnoses of Severe Dementia and Right Sided Weakness. The most recent Minimum Data Set (MDS) dated April of 2011 indicates R4 is total assist for all activities of daily living. The MDS shows R4 is a total 2 person assist for hygiene/bathing. The MDS indicates R4 is not steady in a surface to surface transfer and is only able to stabilize with assistance. The "Occurrence Report" dated 6/01/11 documents R4 was being showered by E9 CNA alone when he (R4) fell from the shower chair and sustained a head laceration that required stitches to close. The report states, "...Notified by CNA res fall in shower room. Assess contusion to (right) forehead...Also, 2 cm (centimeter) skin tear to (right) forehead...Resident sent to (Emergency Department)...Resident received sutures to right forehead area... The statement written by E9 states, "...took resident to shower room to give shower. I turned to turn the water on and resident leaned forward and as I turned back around the shower chair was off the ground and he fell out of chair on the floor and hit his head..." E2 DON stated on 9/29/2011 at 3:00 PM that the policy of the facility is that two staff are to give showers/baths to residents. 3.) The September 2011 Physician's Orders documents R3 has diagnoses of Neurosyphilis, Schizophrenia, Mild Mental Retardation,	F9999		

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	145439	A. BUILDING _____ B. WING _____	10/04/2011

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Dementia, and Paranoia. The 8/14/11 assessment shows R3 is a high risk for falls. The June 2011 Minimum Data Set documents R3 is cognitively impaired, is a two person extensive assist for transfers, is incontinent of bowel and bladder, is not ambulatory and is extensive to total assist for all other activities of daily living.

The Occupational Therapy notes dated 2/3/09 to 2/17/09 states, "...My suggestion is that we make sure that he is all the way back into his seating system and that we use some type of seat belt to make sure that he maintains the position..."

Z7, Director of Therapy stated on 9/28/11 at 11:00 AM that "...yes, I know who (R3) is - he was assessed as needing a seat belt to maintain his posture. He would be unsafe to sit in the wheelchair without a positioning device. He has poor safety awareness..."

The March 30, 2011 Physical Therapy Evaluation and Plan of Treatment states, "...Range of Motion (ROM) (lower extremities) (right lower extremity) Impaired (75 degree contracture at B(Both) knees, patient has had contractures for years per nursing staff. Increased spasticity. Unable to extend knees passively or extend hips past 20 (degrees) flexion...LLE ROM (left lower extremity range of motion) = impaired...increased spasticity..."

The Care Plan dated 7/7/2011 states, "...seat belt on when up in w/c (wheelchair)..."

The Fall Investigation Report dated 8/7/11 reads as follows "...CNA called (nurse) at 3:30 PM to look upon the resident, he (R3) was on the

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floor..." The report documents "Staff did not follow plan ? Seat belt off..."

On 9/28/2011 at 9:30 AM Director of Nursing stated, "...res could remove (unfasten) seat belt. He has done so before on numerous occasions, espescially when he sees the (mechanical lift) because he is trying to help. (R3) has never tried to transfer himself but he does have diagnoses that makes his posture a problem..."

The report to the State Survey and Certification Agency Regional Office dated 8/9/2011 reads as follows: (R3) has been a resident since 11/4/09...On August 7th, 2011 (R3) fell out of his geri chair after he removed his safety belt...An x-ray was ordered for August 8th which determined (R3) had a left hip fracture. He was sent to emergency room for further evaluation. (R3) will be returning to (the facility) after his surgery. A new "alarming safety seat belt" will be in place when (R3) returns..."

On 9/28/11 at 1:30 PM R3 was in his wheelchair. An attempt was made to interview R3. He did not readily respond to questions but did respond to a request for him to unfasten his safety belt. There was no sound when the belt was unfastened that signified the alarm was working. A request was then made that a staff member, E38, Licensed Practical Nurse who had entered the room, try the seat belt. Again the alarm did not sound. After examining the alarm and pushing some buttons the alarm sounded. E38 stated the alarm was not turned on.

4. The October 2011 Physician's Orders documents R2 has diagnoses of Urinary Tract

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F9999	Continued From page 55 Infection and Dehydration.The June 2011 MDS (Minimum Data Set) indicates R2 is an extensive to total assist for all activities of daily living. The MDS shows R2 is a total 2 person assist for transfers. The 6/15/11 assessment rates R2 as a high fall risk. The 8/14/11 "Fall Investigation - Nursing Home - Internal Report reads as follows: Describe the incident: Res (resident) was in process of transfer per (mechnical sling lift) (and) fell... Injury Type: Head Trauma... Witness statement regarding occurrence: I (CNA E55) went into his room to get him up. I put the sling under him and went into the hall to ask a CNA to help me. She said she will be there in a min (minute) so I went in hooked the sling up and lifted him (R2) just a little...Follow - up comments: Root cause - poor transfer technique body shifted in sling when lifted. Intervention - staff education and discipline..." The nurses notes dated 8/14/11 at 4:30 PM states the resident was non-responsive after the fall with fixed pupils non-reactive to light. The notes state R2 was transferred to the hospital with a laceration on the back of his head. The Care Plan dated 6/15/11 states, "...(mechanical lift) (with) 2 assists..." The Physician's Orders dated October 2011 show another resident R1 is a total 2 person assist with transfer. The Care Plan dated 6/16/11 states, "...Assistive Devices as ordered - use (mechanical lift) for all transfers...(mechanical lift (with) 2 assist..." R1 identifed by the facility as an interviewable resident and selected for an individual interview stated on 9/27/2011 at 10:30 AM, "...Sometimes when they transfer me with the lift only one person comes in...This morning when I was transferred (at 6:00 AM), I was transferred by one person..."	F9999		

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F9999	Continued From page 56 The DON stated on 9/29/11 at 1:00 PM the staff members who transferred R1 and R2 admitted that they transferred R1 and R2 by theirselves. The DON stated that both staff members were terminated for their failure to follow facility policy regarding mechanical transfers. B. Based on observation, record review, and interview, the facility failed to provide a safe environment and appropriately supervise one of 11 sampled cognitively impaired residents, out of a sample of 27, by having the electrical cord to the bed plugged into the wall beside and within reach of the resident (R26), resulting in R26 putting the cord around her neck, and attempting to put her fingers into the same electrical socket. Findings include: According to admission records and the POS (Physician's Order Sheet) for 8/11, R26 was admitted on 8/10/11 with multiple diagnoses including Dementia, Debility, Bradycardia with Syncopal episode, and Memory Loss. The Geriatric Rounding Service Note by the Nurse Practitioner on 8/19/11 also added "anorexia and dehydration. . .appetite very poor. . . .refusing to eat. . . .refuses IV (intravenous) fluids. . . .more confused than normal. . . ." The MDS (Minimum Data Set) of 8/19/11 assesses R26 as moderately cognitively impaired, has verbal behaviors, and requires assistance for ADLs (activities of daily living). According to the Occurrence Report dated 8/23/11, at 7:10am, R26 was found with the "black plug-in cord wrapped around her neck.	F9999		

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Cord was not tight. Small amount of emesis was noted on pillow. . . .no red marks. . . " The family was notified and they declined to send R26 to the hospital. A progress note dated 8/23/11 states that a psychological assessment was attempted but "pt (patient) declined services." E39 (day nurse) stated on 9/28/11 that R26 had been asleep when found, and there had been no evidence or verbalizations of suicidal ideations. E39 stated that R26 had been declining and was "just confused."

E39 demonstrated how the bed was set up and where the outlet and plug were. The bed was set with the side of the bed next to the wall (parallel), so the outlet was approximately 18 inches above the mattress toward the head of the bed, within easy arm reach of a resident in the bed. E39 stated they removed the plug and plugged the bed into another outlet. E39 also stated that they placed plastic outlet protector plugs. E39 stated they had talked about moving the bed the other way (perpendicular to the wall), but they did not move the bed into a different position at that time.

Also, E41 (evening nurse) made a written statement that she observed R26 attempting to "put her fingers in the light socket. . . . don't recall seeing plastic protector in outlet. . ." E41 also stated that she lowered the bed and moved the bed "away from the wall so she couldn't reach it."

At 5:30pm on 8/23/11, the Physician Communication and Progress Note by E41 states that R26 "continued to become increasingly confused. . . .would continue these behaviors (fingers in light socket) shortly after being redirected. . . .unable to get IV fluids into her due

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F9999	Continued From page 58 to the continued taking out of the IVs. . . .also refusing to eat/drink anything. . . ." R26 was then sent to the hospital, where R26 was admitted with confusion, tachycardia, UTI (urinary tract infection), and lactic acidosis, according to the Emergency Department Initial Milestone. (B)	F9999		