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	145221	A. BUILDING _____ B. WING _____	09/27/2011

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FAIRVIEW CARE CENTER OF JOLIET	**222 NORTH HAMMES JOLIET, IL 60435**

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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Complaint # 1172631/IL54628-- F309 Complaint # 1172826/IL54491-- F323 An Extended Survey was conducted.	F 000		
F 221 SS=D	LICENSURE SURVEY FOR SUBPART S: SMI 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a siderail was not used on one resident who was not assessed for use of siderails (R4). This is for one resident in the sample of 24. The findings include: On 9/20/11 during the initial tour of the facility R4 was observed up in a wheel chair in the hallway outside of his room. R4 was wearing a chair alarm. Nursing staff informed the surveyor R4 was at risk for falls. Observation of R4's bed noted R4's bed to be a low bed with a mat on the floor at the bedside.	F 221		10/28/11

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

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F 221	Continued From page 1 Review of R4's physician's orders dated 9/8/11 showed orders for a low bed with extra mattress on the floor, sensor pad in the wheel chair, bed bolsters and bed alarm. On 9/21/11 at approximately 2:30 p.m. R4 was observed resting in his low bed. One siderail to the left side of the bed (closest to the wall) was in the up position. Interview with R4 at this time noted R4 to say, "I try to get up sometimes and I will try to climb over this." Review of the facility's fall/incident reports showed R4 has had four incident/falls from 2/20/11 to 9/1/11. One of these incidents showed R4 sustained a 1.5 cm laceration above his right eye. Review of R4's annual MDS (minimum data set) dated 12/24/10 and quarterly MDS dated 9/2/11 showed no indication R4 should have siderail usage. Review of R4's fall care plan showed no intervention of siderail use. Interview with E1(Administrator) and E2 (Director of Nurses) on 9/22/11 noted both to say R4 should not have siderails used.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT 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;	F 225		10/28/11

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F 225	Continued From page 2 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to thoroughly investigate resident allegations of abuse and bruising of unknown origin involving 3 of 24 sampled residents (R1, R3 and R9) and facility staff (E3) failed to report an allegation of abuse	F 225		

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F 225	Continued From page 3 against another employee (E19) to the administrator. Findings Include: On 9/20/11 during the initial facility tour R1 was observed as the resident was laying in bed on her back with her head tilted to the right. R1 stated she was unable to lift her head and was uncomfortable. E3 (nurse) was present and stated that E19 (Certified Nursing Assistant/CNA) was assigned to care for her that day. R1 stated she didn't want E19 to care for her because "she's (E19) mean and hits". When interviewed, by the surveyor, E3 stated that E19 had not had any prior allegations and denied E19 hitting anyone. Also on 9/20/11, during the initial tour, R3 was observed and spoken to. When asked how staff treated him, R3 stated E19 had given him a "hard time" yesterday because he was late coming out of his room for breakfast. She was upset he didn't come to breakfast earlier and most of the residents had finished eating. On 9/20/11 when interviewed about staff treatment, R9 initially stated "they're all right" then hesitated and stated E19 is rough sometimes. Review of E19's employee file revealed that on 10/11/2010 E19 was arrested by the local county sheriff's office and charged with domestic battery. A court date was set for 10/20/2010. E19's 10/29/10 Employee Job Performance Evaluation contained documentation of a below average score. Also observed were multiple Employee Disciplines regarding E19 having been either late	F 225		

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F 225	Continued From page 4 or not coming to work at all. Also observed were two suspensions, one for E19 not having passed residents their breakfast trays; instead E19 took her own break, leaving residents without their breakfast meals and the second suspension due to E19's failure to place a chair alarm on a resident's chair resulting in that resident having an "incident". Another Disciplinary Action against E19 occurred when the nurse entered the room of a resident E19 had been assigned to care for and observed the resident's bed "in the highest position. Resident's feet unable to touch the floor when dangling at bedside. Unsafe condition for resident. Work rule #29, page 54, No work shall be performed in an unsafe manner". Also noted in E19's Employee File was a statement from a nurse regarding E19 when stated that when E19 was informed that a resident had to be gotten up, dressed and have breakfast by a certain time in order to leave (the facility) for an outside appointment. E19 instead ate her breakfast, entered the resident's room later got the resident up and dressed the resident. While the resident was ready to leave for the appointment at the proper time, the resident was unable to eat breakfast before leaving. These disciplinary actions for: E19 consistently addressed E19's noncompliance with the facility's work practices and principles. On 9/20/11, during the Daily Status Meeting,, E1 was informed of R3's allegation about E19. As a result of that information, E19 was removed from contact with residents and suspended. On 9/22/11 surveyors learned E3 had not	F 225		

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F 225	Continued From page 5	F 225		

communicated R1's concerns to E1 or E2. On 9/22/2011 during the Daily Status Meeting with the facility, E1 (Administrator) was informed of the information found in E19's Employee File. E1 stated she had been unaware of the presence of the information regarding E19's arrest.

When the surveyors checked with the state's nurse aide registry, there was not any information of the arrest of E19 having been recorded.

During the initial tour on 9/20/2011, R1 was observed to be a confused and disoriented. During observations of R1's open wounds on 9/21/2011, R1 was observed with extensive discoloration/bruising across R1's upper back, above and below her left elbow. On 9/21/2011, E11 (treatment nurse) stated she had assessed the dark discoloration on R1's left upper back and the area above and below R1's left elbow. E11 described R1's skin discoloration as being caused by rough handling from staff. E11 stated she would need to instruct the certified nurse aides on the appropriate ways to turn and position residents.

On 9/20/11 during interviews with administrative staff (E1/administrator and E2/director of nursing) concerns were expressed regarding R1's complaint of being physically abused by staff. E1 and E2 said an abuse investigation had not been initiated for R1's complaint and they would now start the abuse investigation. During the survey E1 presented the results of the investigation. The investigation was not complete. E1's investigation had no interviews with other residents who had been cared for by E19. Only one other staff member was interviewed. E1 and

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F 225	Continued From page 6 E2 did not perform a complete and thorough investigation of R1's abuse allegation to determine if E19 had exhibited any other abusive behavior.	F 225		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		10/28/11

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This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to conduct comprehensive assessments in the care areas that triggered on the Care Area Assessment (CAA) Summary for 3 residents (R4, R5 and R10) of 24 residents in the sample.

The findings include:

1. Review of R10's admission face sheet showed R10 was admitted to the facility on 7/6/11 with diagnoses including Acute Respiratory Failure, Tracheostomy, MRSA (methicillin resistant staph aureus) and Hypertension. R10 was also observed to have a gastrostomy tube and an indwelling catheter. Nursing documentation also showed R10 had history of Depression and Suicidal Ideations.

Review of R10's MDS (minimum data set) dated 7/13/11 showed on the Care Area Assessment Summary R10 triggered in 12 areas (Cognitive Loss, Communication, Urinary Incontinence/Catheter, Psychosocial Well Being, Mood State, Activities, Falls, Nutrition, Feeding Tube, Dehydration/Fluid Maintenance, Pressure Ulcers, and Psychotropic Medication Use. For location and date of CAA information the specific CAA was identified. Review of the CAA information showed the CAA information was

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either sparse or not found. The CAA information was not separated to address the specific triggered area or the triggered information was not found at all. As noted above, R10 had 12 triggered areas. Review of R10's CAAS showed two areas (Use of Indwelling Catheter, and Activity Preferences Prior to Admission) distinctly identified. Other information on the CAA showed multiple paragraphs stating R10's condition but no comprehensive assessment of the condition was noted.

Information found in one paragraph regarding dehydration only showed, "Resident at risk for dehydration related to tube." Another sentence with no specific CAA specified showed, "Resident on NPO ordered diet. Resident has swallowing problems." Another noted documentation only had a date, time, initials and showed "see fall caas." No fall CAAS was found. Of the 12 triggered areas for R10 only 2 areas (Urinary Incontinence and Activities) were identified to be care planned even though R10 had communication problems, history of depression and suicidal ideations, a feeding tube with possibility of nutrition and dehydration problems, a problem with a pressure sore R10 had developed at the facility, as well as psychotropic medication use due to depression and history of suicidal ideations.

2. Review of R4's admission face sheet showed R4 was admitted to the facility with diagnoses including Hemiplegia, Muscle Weakness, Generalized Pain, and Traumatic Subdural Hematoma. R4's annual MDS dated 12/24/10 showed R4 triggered in 10 Care Areas (Cognitive Loss, Communication ADL's/Functional Status,

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F 272	Continued From page 9 Urinary Incontinence/Catheter, Psychosocial Well-Being, Behavioral Symptoms, Falls Nutrition, Pressure Ulcers, and Psychotropic Medication Use. All of these triggered areas were identified to be care planned. There was no documentation as to the location and date of the CAA information. Review of the CAAS showed information for only 3 of the 10 triggered care areas (Behavior, Communication, and Cognitive Status). The information found for the 3 triggered areas was not specific and not comprehensive. The information was not pulled together to summarize the problem of the care areas risk factors and/or complicating factors. Review of facility incidents showed R4 had 4 falls/incidents from 2/20/11 to 9/1/11 with one incident with a resultant laceration above R4's right eye. The area for falls was triggered. No fall CAA was done. 3. Review of R5's annual MDS dated 2/28/11 showed R5 triggered in 10 Care Areas (Cognitive Loss, Visual Function Communication, ADLs/Functional Status, Urinary Incontinence/Catheter, Falls, Nutrition, Dehydration/Fluid Maintenance, Pressure Ulcers, and Psychotropic Medication Use. All of the triggered areas were identified to be care planned. The location and date of CAA information only showed where information could be found for 5 of the 10 triggered areas. The CAA information location and date for Cognitive Loss, Visual Function, Communication, ADLs/Functional Status, and Urinary Incontinence/Catheter was not identified. IDPH team interview with E20 (MDS Coor) on	F 272		

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F 272	Continued From page 10 9/22/11 regarding CAA information noted E20 to say, "I do the CAAS and summarize everything in paragraphs." E20 did not elaborate on comprehensive assessments or missing information.	F 272		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to administer medications as ordered to 2 of 24 sampled residents (R18 and R24) and 2 residents on the supplemental sample (R29 and R75). Findings include; On 9/20/11 between 1:35PM and 2:30PM, during the 1PM medication pass with E4 (nurse), the following was observed: 1. R18 has 8/31/11 MD orders to include Neurontin 200mg 3 times a day (TID = 9AM, 1PM and 5PM). R18's ordered Neurontin medication was located in the medication cart but not documented on R18's medication administration record (MAR). E4 stated she was unaware of R18's order for Neurontin 200mg TID and did not administer it.	F 282		10/28/11

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2. R75 has current MD orders for Diltiazem 60mg to be administered TID at 6AM, 2PM and 10PM. This order is recorded on R75's September MAR. This medication was available in the medication cart but E4 did not administer this medication.

3. R29 was observed to receive one drop of Brimonidine Tartrate Ophthalmic solution 0.2% into the right eye. R29's MD order includes this medication be administered "to affected eyes every 8 hours."

4. On 9/21/11 at 8:45AM E5 (nurse), observed to administer a Flector patch 1.3% to R24's right knee area.
E5 and R24 both stated this patch is administered once a day at 8-9AM and then removed at 8PM daily.

R24 is assessed as being alert and oriented X 3. R24's 9/01/11 MD progress notes include complaints of knee and ankle pain and diagnosis of Osteo Arthritis.
R24 self ambulates with a rolling walker.

R24's 01/26/11 right knee Xray report and 4/12/11 physical therapy evaluation includes presence of Osteo Arthritis and Osteoporosis.

R24's MD orders include an 8/25/11 order by Z1 (R24's orthopedic MD), for Flector patch 1.3% BID twice a day) to affected area. R24's August 2011 MAR recorded this order as BID but no record that the medication was administered 8/25 - 9/8/11. R24's September 2011 MAR recorded the patch, no location for application included, as administered at 8AM and removed

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F 282	Continued From page 12 8PM daily. No documentation of BID administration or location of application. On 9/21/11 E2 (DON), notified of the above, E2 called Z3 (R24's attending MD) for order clarification of the patch order on 9/21/11. Z3 ordered "Flector Patch 1.3%, apply one patch to right knee twice daily at 6AM and 6PM." On 9/22/11 at 2:15PM R24 was observed in recliner at bedside complaining of right knee pain. R24 stated on 9/21/11 staff only applied one Flector patch on her all day around 9AM, none in the evening. R24 said that the pain affects her ability to walk and that the patch usually helps relive her knee pain.	F 282		
F 309 SS=G	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 observation, record review and interview, the facility failed to: 1) Assess and implement interventions to address pain, and 2) Evaluate and modify approaches for pain when interventions were ineffective. This is for 2 residents (R1 and R9) in a sample of 24. These failures resulted in R1 experiencing	F 309		10/28/11

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frequent episodes of avoidable pain due to ineffective management and R9 experiencing frequent pain without evaluating the effectiveness of the interventions. .

Findings include:

1. On 9/20/11, during the initial tour R1 was observed crying, groaning and complaining of pain. R1 complained to E3 (nurse) that she had pain. E3 administered Morphine Sulfate 0.5 ml via G tube to R1 without assessing the severity or location of the R1's pain.

On 9/21/11 R1 was observed lying in bed. R1 stated that she was still in pain. R1 stated "the pain is in my abdomen." On a scale of 1 - 10 R1 rated the pain at a "10."

During an interview on 9/21/11 at approximately 11:30 AM, E23 (nurse) stated that R1 receives her pain medication every 6 hours, and that R1 had her last dose at 8:00 AM.

Review of the Medication Administration Record (MAR), verified R1 received the pain medication at 8:00 AM, but R1 also had other pain medication ordered. E23 had not re-assessed R1 to ensure the pain medication was effective nor did E23 offered additional pain medication to decrease R1's level of pain.

Review of R1's Physician Order Sheet (POS) showed orders for the following pain medications: Morphine Sulfate 15 mg po (by mouth) every 8 hours, Morphine Sulfate 15 mg every 6 hours prn (as needed)Duragesic patch 25 mcg topically every 72 hours, Lidoderm Patch , 1 patch

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F 309	Continued From page 14 topically to back and change daily on 12 hours and off 12 hours. Neither Nurses Notes nor MARs for August, 2011 and September, 2011 consistently document the severity of R1's pain when medications where administered. Nor is there documentation of the Lidoderm patch having been applied as ordered. R1's care plan for pain listed interventions such as "note characteristics of respirations, instruct to rate pain if she can on a scale from 1-10 ...document pain level, administer pain meds, monitor/record med effectiveness, and side effects. Teach pain relievers: massage/ice exercise...assess for pain, response to pain medication/prn use or need to adjust dose and discuss with MD". None of these listed interventions were followed on a consistent basis, nor were other interventions initiated when the current interventions were ineffective. Review of R1's Controlled Drug Form for August,2011-Sept, 2011 documented the frequent administration of Morphine Sulfate Solution 0.5 ml (10 or 15 mg) sublingually every 2 hours as needed for pain or air hunger. This medication was administered 50 times between 8/9/11 and 9/24/11. Further review of R1's POS revealed that there was no order for the Morphine Sulfate to be administered every 2 hours. As noted above, R1 had physician's orders for 15 mg. to administered every 8 hours or every 6 hours PRN (as needed). During an interview with E2 (DON), regarding the discrepancies of the Morphine Sulfate administration, E2 stated "That was an error, I	F 309		

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F 309	Continued From page 15 was hoping that you would not catch that." Review of nursing documentation did not indicate that R1 was assessed for break through pain or alternative interventions in an attempt to minimize her pain. 2). Current physician's orders for 9/2011 shows R9 has diagnoses which includes cancer with metastasis. Nursing documentation shows R9 frequently complains of pain. The physician orders show that R9 has pain medication ordered and is on hospice. Review of the MAR and Nurses notes verified that nurses do not consistently document R9's location, characteristic, or severity of pain. According to the MAR, R9 received Norco 325/7.5 mg for pain on 8/25/11. Nurses notes for the day do not mention R9 having pain. There is also no documentation of location, characteristics or severity of R9's pain. According to the August 2011 MAR, R9 again received Norco 325/7.7. Again the nurses, did not assess R9's pain On 9/22/11 while in R9's room with Z1, E3 entered the room. R9 told E3 that he was in pain. E3 obtained Morphine liquid and administered the morphine without assessing R9's location, characteristic or severity of pain. Review of nursing documentation showed a pattern of lack of assessment of R9's pain. The facility has also developed a care plan for R9 which addresses his pain. Interventions of :	F 309		

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F 309	Continued From page 16 --teaching R9 pain relievers, --massage/ice /exercise, --document pain level, --note characteristics of pain, --assess the resident for pain, --response to pain medication/prn use or need to adjust dose and discuss with MD. These interventions for R9 have not be been consistently implemented by nursing staff.	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, record review, and interview the facility failed to: 1. Prevent 1 resident (R10) from developing a stage III pressure sore while in the facility. 2. Provide descriptive documentation and develop a plan of care for 1 resident's pressure sore (R15). 3. Assess the nutritional status for 1 resident's pressure sore (R15). As a result of this failure R10 acquired a painful stage III pressure sore to the coccyx.	F 314		10/28/11

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F 314	Continued From page 17 This is for 2 residents in the sample of 24. (R10 and R15) The findings include: 1. Review of R10's admission face sheet and current physician's orders (Sept. 2011) showed R10 was admitted to the facility on 7/6/11 with diagnoses including Acute Respiratory Failure with Tracheostomy, MRSA (methicillin resistant staph aureus), and Hypertension. Nursing documentation showed R10 has history of depression and suicidal ideations. Observation of R10 on 9/20/11 showed R10 also has a gastrostomy tube and an indwelling catheter. Review of the facility's Pressure Sore Log showed R10 acquired a stage II pressure sore to the coccyx at the facility on 8/30/11 which measured 2.0 cm x 2.4 cm at this time. On 9/22/11 at 10:20 a.m. E11 (RN - Wound Nurse) was observed performing treatment to R10's coccyx pressure sore with E13 and E14 (CNA's) providing standby assist. E11 removed R10's old dressing. R10's coccyx site remained open with yellowish tissue and slight thin serous drainage. The coccyx site was now 2 sites which was connected by a "skin bridge." The larger site measured 1.6 cm x 1.0 cm. The smaller site measured 1.0 cm x 0.4 cm. Interview with E11 at this time noted E11 to say R10's coccyx pressure sores now are stage III's. Observation of the sites noted both sites to be at stage III. Pressure sore log documentation dated 9/18/11 (4 days prior) for R10's coccyx site showed R10's site staged as a stage II with measurements at that	F 314		

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F 314	Continued From page 18 time being 1.7 cm x 1.8 cm x 0.1 cm. Observation of R10's pressure sore on 9/22/11 showed R10's pressure sore has divided into 2 pressure sores and have worsened to stage III's. During the pressure sore treatment R10 was observed pulling away and complaining of pain when E10 touched the pressure sore site. During interview with E11 on 9/22/11, E11 was questioned why R10 developed the pressure sore to the coccyx. E11 stated, "R10 won't stay on his side. We try to prop him over with pillows but he won't stay over." No other reasons were given and no other interventions to keep R10 off of his back were mentioned. Observation of R10's right heel during the pressure sore treatment noted R10's right heel to be reddened, but blanchable. R10 had no boot/heel protector on while in bed and no intervention for heel boot/heel protector addressed on his plan of care. Review of R15's admission face sheet showed R15 has had multiple admissions and discharges from this facility. R15 was readmitted to the facility on 6/1/11. Nursing documentation of 7/3/11 contains the first mention of R15 having a pressure sore on the coccyx and right lower buttocks. On 7/11/11 staff documented R15 had an open area on the left mid buttocks; no measurements were given.	F 314		

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F 314	Continued From page 19 E11 (Treatment Nurse) was interviewed regarding R15. As stated by E11, R15's pressure ulcers started off as excoriation on her buttocks due to diarrhea, which was treated. From this R15 developed a small open area on the coccyx, stage 2. When E11 was asked about pressure sore documentation, E11 stated, "Descriptive documentation of wounds and pressure sores can be located in the nurses notes." Review of nurses notes for R15 showed the documentation of the pressure sores/open areas was not clear or consistent. There was no clear documentation of the appearance of R15's open areas/pressure sores, nor was there descriptive documentation regarding the size, depth, surrounding tissues etc... Review of dietary notes showed there was no appropriate nutritional assessment for R15. In the dietary note of 7/7/11 dietary staff wrote that R15's skin was intact. Nursing documentation showed R15 had an open area on the coccyx and on the right lower buttock at this time. Review of R15's plan of care showed no care plan was developed to address the presence of R15's multiple pressure sores and open areas.	F 314		
F 317 SS=G	483.25(e)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.	F 317		10/28/11

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This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to ensure that one resident (R18 in a sample of 17 residents with concerns for limited range of motion.) received all the appropriate services to ensure that the resident's ROM (Range of Motion) did not decline.

This failure resulted in R18 experiencing a decline in ROM within the three months that he resided in the facility.

Findings include:

Review of R18's Admission Face Sheet documented that R18 is a 54 year old male with diagnoses including Cardiovascular Accident with Right Hemiplegia. R18 was admitted to the facility on 5/06/2011.

Review of R18's Physician Order Sheet documented the following interventions for R18: "Right hand splint while up in wheel chair; off for direct care."

Review of R18's Initial Restorative Nursing Assessment, dated 5/07/2011 at 6:19 PM, documented the following ROM for R18: Right fingers = normal mobility, right elbow = normal mobility, right wrist = normal mobility, right hip = normal mobility, right knee and ankle = normal mobility.

Review of R18's most recent Restorative Nursing

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F 317	Continued From page 21 Assessment, dated 8/15/2011 at 6:15 AM, documented the following decline in ROM for R18: right fingers = "Severe, less than 50% normal mobility", right elbow = "Severe, less than 50% normal mobility", right wrist = "Severe, less than 50% normal mobility", right hip = "Severe, less than 50% normal mobility, and right knee = "Severe, less than 50% normal mobility, and right ankle = "Severe, less than 50% normal mobility". Review of the flow sheet used to record "Restorative All shift" care, dated from June/2011 to September 2011, did not document facility's staff providing consistent restorative services to R18. Several days each month were left blank without any documentation indicating why. A majority of the documentation recorded R18 only wearing his right hand splint for 15 minutes. On 9/20/2011 1:30 PM to 2:30 PM, 9/22/2011 10:10 AM and 11 AM, and 11:30 AM R18 was observed sitting in the day room in his wheel chair without his splint being applied to his right hand or any device/position to prevent contractures to his right leg and ankle. When interviewed on 9/22/11 at 11:30 a.m., R18 stated he could only open the fingers of his right hand with help; that he couldn't open them spontaneously. R18's right hand was slightly contracted and his entire right arm was flaccid. Immediately prior to the interview, R18's right hand splint was obseved laying on the top of his bedside table. On 9/22/2011 and 9/24/2011, R18 was interviewed in his room and day room. R18 was observed to be alert and talkative. When asked R18 stated "staff did not always put on his right	F 317		

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hand splint, or do daily ROM exercises." R18 expressed his fears that he was loosing the use of his right hand, and staff were not providing him with the care he needed.

On 9/24/2011, the restorative certified nurse aide (CNA) was observed in R18's room. E10 (restorative aide) reported that R18 was admitted to the facility in the middle of March 2011, and had experienced a decline since being admitted. E10 stated "R18's right elbow and right knee has become more contracted since admission." When asked, E10 said she did not know why R18 has decline in ROM.

On 9/24/2011 at 10:05 AM, the restorative nurse was interviewed. E11(restorative nurse) stated that R18's initial restorative assessment was done on 5/07/2011. The goal was to increase R18's ROM by 8/17/2011. E11 was asked to review R18's admission nursing restorative notes dated 5/07/2011 and most recent nursing restorative noted dated 8/11/2011. After reviewing R18's admission restorative assessment and the current restorative nursing assessment, E11 stated that R18 had decline in the following areas: right elbow, right wrist, right hip and right knee. When asked, E11 said she did not know why R18 was declining in ROM. While reviewing R18's restorative care plan and documentation of care, E11 could not tell why some days were left blank. When asked was it appropriate to apply R18's splint for only 15 minutes, E11 replied, "R18 required more than 15 minutes for his splint to be effective." E11 could not give any reasons why R18 had a decline in ROM. E11 also could not identify any changes that were done to R18's restorative program to

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F 317	Continued From page 23 prevent further decline in R18's ROM. During a meeting with the facility's administrative staff (administrator/E1 and director of nursing/E2), on 9/22/11, the surveyor team expressed concerns that R18 was not receiving the appropriate care to prevent decline in his ROM. Up to date of exit on 9/27/2011, E1 nor E2 provided any evidence to support that R18 received the appropriate services and consistent care needed to prevent decline in ROM.	F 317		
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: Based on observation, record review, and interview the facility failed to: 1. Provide supervision to residents to prevent falls, serious injuries, and/or fractures. This occurred for 4 of 24 sampled resident (R10,R17,R19 and R20) and 4 residents in the supplemental sample. (R26, R86, R138, R91). 2. Provide supervision and develop effective interventions to prevent residents in the sample with tracheostomies from consistently extuba-ting themselves. (R10 and R19). 3. Develop, implement, and maintain a system to	F 323		10/28/11

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track residents' falls, failed to identify the circumstances why falls occurred, and failed to analyze patterns and trends of falls and incidents occurring at the facility.

As a result of these failures:

1. R26 had 3 falls from 7/25 to 8/8/11 and sustained a fracture to his lumbar spine.
2. R86 had 2 falls on 7/10 and 8/14/11 and sustained a closed head injury and fracture to the left shoulder.
3. R138 had a fall on 8/27/11 and sustained a fracture to the left hip.
4. R91 was injured while being transferred to bed and on 8/4/11 hospital documentation showed R91 had sustained a torn meniscus and fracture to the left knee.
5. R20 had several falls and incidents and sustained a bruise to his back.
6. R10 was noted to have extubated himself 13 times from 7/13 to 9/19/11.
7. R19 was noted to have extubated himself 3 times from 7/18 to 8/2/11.
8. R17 fell twice within two days of admission to the facility, hit her head on the second day of admission and was admitted to an area hospital, to the Intensive Care Unit with diagnoses of head injury and intracranial bleed.

The findings include:

1. Review of R26's admission face sheet showed R26 has diagnoses which includes Cerebral Vascular Accident, Hypertension, and Coronary Artery Disease. Nursing documentation showed R26 had history of falls.

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During review of the facility's incident reports R26 was noted with 3 incidents/falls from 7/25/11 to 8/8/11. Incident documentation showed on 7/25/11 at 9:40 a.m. R26 attempted to transfer himself from the toilet back into his wheel chair and fell. Incident documentation showed R26 started complaining of severe back pain on 7/27/11 and was sent to a nearby hospital for evaluation. R27 was admitted to the hospital with diagnosis of fracture to the lumbar spine. Review of CT (computerized tomography) from the hospital dated 7/27/11 showed the following:

R26 had a "moderate to marked compression fracture of the L1 vertebral body which does have a diffuse increased density. This may be possibly subacute in nature. There is, however a question of some mild paraspinal soft tissue edema at this level which could have a recent component associated with it There is a faint line projected through the right-sided posterior margin of the L1 vertebral body with the pedicle consistent with a non displaced fracture line at this level. "

The CT scan also showed R26 "had slight wedging of the L2 and mild loss of height of the L3 vertebral body with mild impressions noted in the endplates at L4 and L5. Varying degrees of disc space narrowing noted, most pronounced at L5-S1."

R26 was readmitted to the facility on 8/3/11. Nursing documentation showed R26 complained of moderate pain during therapies and during care. Nursing documentation also showed R26 MUST WEAR BACK BRACE WHEN UP. Review of R26's plan of care for falls presented with the

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incident follow up report showed no intervention for R26 to wear his back brace. The follow up report notes, "Facility will continue to monitor and provide safety according to Plan of Care."

Nursing documentation and incident documentation showed R26 had a fall in his room on 8/6/11 and a fall in the bathroom on 8/8/11. Documentation for the fall of 8/8/11 showed R26 put himself on the toilet, fell back against the toilet tank completely breaking the tank. R26 was sent back to the hospital for x-rays and admitted to to the hospital with diagnosis of TIA (trans ischemic attack). R26 was readmitted to the facility again on 8/11/11.

Observation of R26 9/23/11 at 10:20 a.m. noted R26 to be sitting in his electric wheel chair in the second floor dining room. R26 was noted with a Velcro wrap back support in place. Interview with R26 at this time noted R26 to say, "I think that I fell out of bed when I fractured my back. The second time when I fell and had to go to the hospital I was trying to go to the bathroom. I don't remember what happened."

As mentioned above; review of R26's plan of care addressing falls showed no intervention which included wearing a back brace. There was no description of R26's back brace and no instructions on how the brace is to be applied. The fall plan of care showed no intervention for more frequent observation of R26 in an attempt to try to prevent further falls/injuries. The fall plan of care showed an intervention that R26's room should be moved closer to the nurses station. R26's room was observed to be approximately half way down the hallway where he resides.

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2. Review of incident reports for R86 showed on 7/10/11 R86 was in the bathroom, got dizzy, fell, and hit his head on the toilet. R86 was sent to a nearby hospital where he was admitted with diagnoses of closed head injury. Incident reports showed on 8/4/11 R86 again fell in his bathroom while toileting and complained of pain to the right ankle. Nursing documentation showed R86 experienced pain "if he tried to walk." Further nursing documentation showed R86 had NO HISTORY OF FALLS (PAST 3 MONTHS) even though R86 had fallen on 7/10/11 (approximately 3 weeks prior) and sustained a closed head injury.

Further review of incident reports showed on 8/14/11 at 2:30 PM R86 reported he had fallen in his room while transferring back to bed. R86 complained of pain to the left shoulder. Stat x-rays were taken of R86's left shoulder with results which showed "Non displaced fracture of the greater tuberosity and suspicious fracture of the neck of the left humerus." R86 was admitted to the hospital with diagnosis of Hypotension. On 8/14/11 R86's blood pressure at 4:15 p.m. was documented at 108/68. R86's plan of care addressing falls includes "monitor for any evidence of hypotension."

3. Review of R138's closed record and incident report dated 8/27/11 showed conflicting information on the incident report and nurses notes. The incident report dated 8/27/11 showed time of occurrence at 11:00 p.m. and noted during rounds the nurse found R138 on the floor. Review of nursing note documentation showed on 8/27/11 at 5:15 p.m. R138 fell in his room

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while transferring to a chair. Nursing documentation showed NO APPARENT INJURY even though skin tears were documented and x-ray of the left hip and femur were ordered. Initial facility x-rays of the left hip and femur were negative. Facility incident report goes on to note R138 saw an outside physician on 9/2/11 and was found to have a hairline fracture of the greater trochanter.

Review of a hospital x-ray dated 8/30/11 showed R138 was identified with a left hip fracture on 8/30/11 not 9/2/11. The hospital x-ray showed "There appears to be fragmentation and slight linear lucencies extending through the greater trochanteric of the left femur. Configuration raises the possibility of cortical fractures about the greater trochanter left femur."

Further review of nursing documentation for R138 showed on 8/26/11 at 11:00 p.m. R138 fell in his room while transferring to bed. At this time R138's blood pressure was noted at 94/66. On 8/27/11 at the time of R138's fall his blood pressure was documented at 100/58. No plan of care was presented to address R138's hypotension and prevention of falls.

4. Review of an incident report for R91 and interview with E2 (Director of Nurses) showed conflicting information. Incident report review showed R91 had an incident (date unknown) while being transferred to bed R91's knee was hit on the bed frame. Incident documentation showed R91 stated this happened one week before she was hospitalized on 8/4/11. Review of the incident follow-up report dated 8/17/11 showed R91 returned to the facility on 8/16/11,

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had follow up appointment in 1 week with ortho, and had no change in functional status.

On 9/22/11 at approximately 2:30 p.m. E2 (Director of Nurses) was questioned regarding the incident with R91 bumping her knee while being transferred to bed. E2 stated R91 went to the hospital for a medical problem and they checked her knee there. E2 stated, "R91 didn't have any fracture, she had an effusion."

On 9/23/11 at 11:00 a.m. R91 was observed receiving dialysis in the facility's dialysis unit. R91 was alert and verbally responsive. During interview with R91 at this time about the incident with bumping her knee R91 started, "I have an electric wheel chair. When the CNA was putting me to bed she didn't turn off the wheel chair. It got away from her and it jumped and my knee hit the bed rail. It hurt bad. They did x-rays at the hospital but the MRI showed I had a hairline fracture and something else wrong with my knee."

R91's MRI results were requested and reviewed. R91's MRI results were dated 8/8/11. Review of the results showed documentation of the following injury:

Impression:

1. Tear in the posterior horn and body of the lateral meniscus.

2. Nondisplaced fracture within the lateral tibial plateau which extends to tibial spine and visualized proximal tibial shaft. The most distal aspect of the fracture component is beyond the

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border of these images. In addition, there is about a 2 mm impaction of the fracture along the anterior aspect of the lateral tibial plateau.

During interview with R91, R91 stated, "My knee still hurts sometimes and I still have to take pain pills for the pain."

Review of R91's plan of care showed no interventions regarding instructions on operating R91's wheel chair when transferring R91 to and from the wheel chair. E2 also did not note that staff had been inserviced/trained on operating R91's wheel chair to prevent further accidents.

5. Review of incident reports for R20 showed R20 had 7 falls from 4/14/11 to 9/21/11. During most of R20's falls there is documentation that R20 is in his recliner chair in his room and is found on the floor. With one fall R20 is noted with bruising on his back. Confidential interview on 9/22/11 notes that R20 is usually put in his recliner chair with the feet elevated so "he can't get up." Also noted with R20's falls his blood pressures vastly fluctuates from 115/59 to 161/115.

Review of R20's plan of care shows no follow up in evaluating R20's blood pressure fluctuations in an attempt to determine R20's falls. The plan of care also does not address positioning of R10 in his recliner chair or other interventions to prevent R20 from falling out of his recliner chair.

6. Observation of R10 on 9/22/10 at 10:20 a.m. noted R10 to be resting in bed. R10 was observed with a tracheostomy in place connected to a trach cuff and oxygen at 5L/min. R10 was in

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contact isolation for MRSA (methicillin resistant staph aureus). R10 also had a gastrostomy tube, and an indwelling catheter. Nursing documentation dated 7/22/11 on the CAA's (care area assessments) showed R10 has history of depression and has voiced suicidal thoughts.

Review of nursing documentation from 7/13 to 9/19/11 showed R10 had pulled his tracheostomy tube out 13 times. During some of the times R10 had extubated himself, he had also pulled out and/or pulled on his gastrostomy tube and indwelling catheter. R10 was observed to be wearing hand mitts on 9/22/10. Review of R10's plan of care showed interventions that R10 had hand mitts ordered at times and wrist restraints ordered at other times. On 8/18 and 8/22/11 R10 also had an intervention for R10 to be monitored every 30 minutes. Review of nurses notes showed R10 had extubated himself 6 times after the intervention was developed to monitor him every 30 minutes.

No other successful interventions were addressed/developed to prevent R10 from pulling on his tracheostomy to prevent him from extubating himself or from pulling on his gastrostomy tube and indwelling catheter.

During interviews with E1 (Administrator) and E2 (Director of Nurses) on 9/23/11 both admitted that the facility does not keep a tracking log to track individual resident's falls/incidents. Both admitted the facility has no Fall Committee to address resident falls and both admitted no one is analyzing or identifying the circumstances for why the falls are occurring. The facility is not identifying whether there are fall patterns and/or

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F 323	Continued From page 32 trends of resident falls and incidents. E1 and E2 did present Incident/Accident Report Summaries for July and August 2011. These reports showed numbers and data collection but no individual analysis or summary of conclusion to identify an individual decrease in falls/incidents for any resident. Further review of these summaries showed they were not accurate/complete. The July 2011 summary sheet included a section identifying "Residents involved in more than one (1) incident this month." This section had initials of residents who had more than 1 incident in July. R20 had 2 documented falls in July. R20's initials were not included on this summary sheet. 7. Review of R19 Admission Face Sheet document R19 is a 73 year old male with diagnosis including: Generalized Muscle Weakness, Acute Respiratory Failure, Intermittent Confusion, and History of Neck Fracture. Review of R19's Nursing Notes documented that R19 pulled out his tracheostomy tube several times. The nursing notes document the the following: 7/18/2011 6:35 PM Alert, oriented to time... person... to place... staff assist needed... pulls at tubes at time...has difficulty making decision in new situation. 6:44 PM Level of Consciousness/Mental Status Intermittent Confusion, chair bound, legally Bind... 9:30 PM Called to resident's room, has pulled out	F 323		

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F 323	Continued From page 33 trach tube. Reinserted... small amount of bleeding noted." 7/19/2011 12:35 PM Decreased range of motion. Decline in muscle strength. Resident restrained for: behavioral symptoms: trying to pull out tracheostomy tube. Restraint prevented behavior from occurring. Contributing problems: confusion... Use bilateral mitts at all times... Resident has a life threatening condition..." 7/21/2011 11:11 PM Pulled out trach from site... Interventions: transferred to emergency room..." 7/27/2011 12:05 AM... Trach out... Resident room...Resident in bed" R19's Nursing Notes also documented that R19 had 7 falls between 7/18/2011 to 8/25/2011. The nursing notes documented that R19 fell on the following days: 7/18/2011, 7/21/2011, 7/27/2011, 7/31/2011, 8/02/2011, 8/17/201, 8/21/2011, 8/22/2011 and 8/25/2011. The facility incident report that documented R19 pulling out his trach and falling on 7/21/2011 was reviewed. This was after R19 demonstrated he was confused and had exhibited the behavior of pulling out his tracheostomy tube. Staff interviews documented that they walked into R19's room around 7 PM and noticed R19's trach was out. Staff stated R19 could remove his mitts. Also, all staff interviewed noted that they last observed R19 approximately an hour ago (5:30 PM or 6:15 PM). This indicated R19 was not being closely monitored for the behavior of extubating himself.	F 323		

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F 323	Continued From page 34 On 9/22/2011 at 10 AM, E9 (nurse) was accompanied to R19's room to observe what interventions were in place to prevent R19 from falling. E9 stated that R19 was at risk for falls. E9 also stated R19 had mats on the floor, boosters in the bed, and chair and bed alarms to prevent him from falling. However; R19 was observed in his wheel chair, sitting alone in his room, with no chair alarm attached. When asked about the absence of the chair alarm, E9 stated R19 should have one. R19 stated he did not need the chair alarm. The CNA for R19 entered the room. When asked about the absence of R19's chair alarm, the CNA stated, "R19 told me not to put it (chair alarm) on." This showed the nursing interventions identified to prevent R19 from falling were not being consistently implemented. E21 (nurse) was identified as taking care of R19 on 7/21/2011, when R19 pulled out his tracheostomy tube. E21 was interviewed on 9/27/2011 at 11:39 AM. When asked, E21 stated R19 has removed his tracheostomy "a couple of times". E21 also stated, "R19 did not want it in and he pulled it out. We've had to put his trach tube back in before. A couple of times, we sent him out to the hospital to get it back in." E22 (nurse) was identified as caring for R19 on 7/27/2011, when he removed his tracheostomy tube. E22 was interviewed on 7/27/2011 at 11 AM. E22 stated, "I went in there and it was out. At times he could get his mitts off. I just remember I went in there and it was out. I think there's been a few times he went to the hospital because it could not be reinserted".	F 323		

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Review of R19's plan of care addressing R19's tracheostomy showed there was no consistent and effective interventions in place to prevent R19 from pulling his trach tube out (extubating himself) to prevent bleeding and irritation to the trach tube site.

8. R17's closed record was reviewed. R17's admission face sheet showed R17 was admitted to the facility on 9/1/11 with diagnoses including Altered Mental Status, Vascular Dementia, Muscle Disuse Atrophy and Abnormality of Gait. R17 was admitted to this facility from another area nursing facility. The transferring facility sent background information about R17's illness and the course of care that R17 had received at the prior facility.

Information sent with R17 from the previous nursing facility clearly documents R17's dementia, inability to follow commands, poor cognition, confusion and disorientation, Cerebral Vascular Accident (CVA), and Muscular Disuse Atrophy.

E17 Certified Nursing Assistant (CNA) had been assigned to provide care to R17 during R17's short stay at the facility.
E17 described R17 as "very confused and disoriented with a contracted left leg." "R17 was not ambulatory and needed a mechanical lift to transfer."

Review of nurses notes and facility incident reports showed on 9/2/11 at 11:43PM, (the day after R17 was admitted to this facility), "R17 was found on the floor. R17's mental status post fall was assessed as "same as baseline".

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On 9/3/11 R17 was found on the floor again. On this date E17 (CNA) found R17 on the floor. According to E17 on 9/3/11 while doing rounds E17 walked into R17's room and found the resident on the floor with the wheelchair behind her. R17's legs were underneath the wheelchair. R17 was not unconscious, but was not responsive to verbal stimuli. E17 returned the resident to bed. R17 would squeeze E17's hand and look at her, but not talk. E17 stated, "This is a change in mental status from the day of R17's admission." When found on the floor R17 was bleeding from her forehead.

E17 stated she never observed R17 in the wheelchair. E17 stated, "On 9/1/11 R17 stayed in bed until therapy could assess her. On 9/2/11 I was off work and on 9/3/11 I found R17 on the floor." E17 continued to say when R17 was first admitted they (CNA's) were told R17 was confused and to "watch her" and to keep an eye on her. E17 stated that CNAs get report on residents, then they do rounds. E17 stated, "There was not any special information provided on R17 other than the fact that R17 was up in the chair."

E18 (nurse) also cared for R17 during her stay. E18 stated she worked 6:30AM to 3:00PM on the day that R17 was found on the floor (9/3/11) . E18 also described R17 as having contracted bilateral knees and totally dependent for mobility. Regarding R17's mental status, E18 stated R17 would only look at her, nothing more. E18 stated, "On 9/3/11 R17 was not very alert in the morning but was more alert in the afternoon. R17's son came to visit at 2:30PM and brought

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R17 lunch. The son was surprised at the level of R17's alertness. R17 was sitting in the wheelchair."

E18 stated R17 was cognitively and physically unable to propel herself in the wheelchair and wasn't ambulatory at all. E18 stated she had just finished report when she heard E17 say that R17 was on the floor. When E18 saw R17, R17 was laying face down on the floor bleeding from the middle of her forehead. R17 was nonverbal and looking around aimlessly. CNAs got the mechanical lift to return R17 to bed.

Facility nurses notes and fall assessment both assess R17 as having difficulty walking and with poor balance. The nurses notes and fall assessment also showed R17 as having both short and long term memory problems, severely limited ability to walk, unable to bear weight or communicate, being immobile, and with a wheelchair as the primary mode of locomotion. Facility staff also assessed R17 in need on one staff to transfer.

The initial fall care plan for R17 was initiated 9/1/11 and assessed R17 as high risk for falls. The listed interventions included instructions to:

1. Ask for assistance prior to attempting to transfer or walk.
2. To place the call light within easy reach
3. Encourage R17 to use the call light prior to attempting to walk or transfer.

These interventions were not realistic, but were implemented even though the facility's own staff had assessed R17 as as having difficulty walking

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and with poor balance, as having both short and long term memory problems, as having severely limited ability to walk, not being unable to bear weight or communicate, being immobile, and with a wheelchair as the primary mode of locomotion. R17 was also in need on one staff to transfer.

Further review of R17's incident report for 9/3/11 showed at 3:35 p.m. R17 was found on the floor with a laceration (no area specified). Incident documentation showed R17 was sent to a nearby hospital where she was admitted to the Intensive Care Unit (ICU) with diagnoses of Head Injury and Intracranial Bleed.

Based on observation and interview the facility failed to place shower call light strings in such a manner that they were easily able to be used by residents.

This failure affected 6 of 24 sampled residents, R1,R4, R11, R12, R14 and R24 and multiple residents in the supplemental sample.

Findings include:

During the survey on 9/21/11 and 9/22/11 the call light strings in the shower rooms on 200 wing, 300 wing, 500 wing, 2400 wing, 2500 wing and room 402 were tied to the grab bars and could not be pulled if the call string was grabbed below the grab bar. Residents interviewed stated that they were not able to activate call lights in the shower room.

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F 323	Continued From page 39 Residents that could be impacted by these call lights are R25, 28, 24, 11, 49, 51, 60, 64, 74, 80, 12, 100, 108, 111, 114, 117, 125, 128, 124, 32, 27, 35, 19, 50, 55, 66, 79, 87, 99, 124, 14, 62, 63, 70, 71, 72, 83, 89, 93, 102, 105, 107, 126, 129, 132, 29, 33, 42, 43, 44, 46, 61, 67, 4, 75, 77, 87, 91, 96, 97, 101, 120, 131, 135, 6, 31, 37, 38, 39, 40, 1, 52, 56, 69, 92, 113, 133 and 136.	F 323		
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure food is served at the proper temperature as measured at the noon meal on 9/22/11. This has the potential to affect all 122 residents eating in the facility. Findings include: During the group interview on 9/21/11 R 72, R100, R102, R107, and R135 said the food is not always hot. During an individual interview on 9/22/11 R105 also said the food is not hot. Review of food committee meetings of 6/22/11 state "food gets cold up-stairs- CNA's not around." Food committee meeting of 9/21/11 state "veggies need to be hotter. And more variety."	F 364		10/28/11

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F 364	Continued From page 40 Temperatures of food were taken on tray sent to the 2nd' floor at the noon meal on 9/22/11. At 12:35PM there were two trays left to serve temperatures measured on sample tray were as follows: grilled cheese, rice pilaf, and peas were all 98 F. apricots were 60F. Milk was 54 F. and coffee was 140 F. Food did not taste hot at these temperatures, and the cold food was not cold. Food is sent up to the second floor on trays from the kitchen. The plates are covered but there is no heat retaining equipment to keep the food hot while trays are being passed out.	F 364		
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 and interview, the facility failed to ensure the low temperature chemical dish washing machine was monitored to ensure the proper concentration of chemical sanitizer was being used. This had the potential to affect all 122 residents who eat in the facility. Findings include:	F 371		10/28/11

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F 371	Continued From page 41 During the tour of the main kitchen in the morning of 9/20/11 the chemical dish machine was observed. E6, the food service supervisor, said he does not have the correct test strips because the machine is fairly new in the facility. On 9/21/11 E6 said he called the chemical supply company to request the test strips and a copy of the manufacture's directions for the machine. A dish room chemical documentation form was started on 9/22/11 which states " This form must be filled out completely prior to washing each meal. Use the white test strips provided and compare to color chart." The areas to be filled out include the chemicals are full and chlorine is 100 ppm. E6 was not able to obtain a copy of the manufacture's guidelines for the machine as of 9/22/11.	F 371		
F 406 SS=E	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to: (1) provide individualized services for residents who have serious mental illness (SMI) as	F 406		10/28/11

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F 406	Continued From page 42 determined by a comprehensive assessment and to assist residents in achieving as much independence as possible. (2) re-evaluate, develop, implement and coordinate Psychiatric Rehab Service (PRS) programs and/or drug and alcohol abuse rehab services This failure effects 4 residents (R2, R6, R7, R21) in the sample of 24 and 4 residents, (R40, R71, R107 and R109) in the supplemental sample who were identified with serious mental illness. Findings include; 1. During the survey, the administrator (E1) identified 8 residents with having a severe mental illness: R2, R6, R7, R21, R40, R71, R107, R109. This list also documented all the resident attended the same psychosocial groups on Saturdays. When asked, E1 stated the facility only offered two psychosocial groups on Saturdays. E1 said both groups were open to any residents. But, E1 did not identify the individual therapeutic needs or goals for R2, R6, R7, R21, R40, R71, R107 or R109 to participate in this weekly psychosocial rehab program. Review of R2, R6, R7, R21, R40, R71, R107 and R109's Pre Admission Screening/ Mental Health Screening documented the above residents had a history of Severe Mental Illness and psychosocial rehab programing was indicated. 2. Review of R7's Admission Face Sheet documented that R7 is a 41 year old male with a diagnosis of serious mental illness such as: Schizoaffective, Depressive Disorder and Alcohol	F 406		

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F 406	Continued From page 43 Intoxication. Review of R7's Physician Order Sheet documented R7 is being treated with the following psychoactive medications: Fluoxetine 20 mg every morning Seroquel 100 mg at every night at bedtime Trazodone 50 mg every night at bedtime Seroquel 50 mg twice a day Review of R7's POS also documented he : "May Go Out on Pass with Meds and Instruction." Review of R7's psychosocial notes documented he had problems with feelings of depression, staying up at night, noncompliance with psychosocial and drug rehab programs, needing supervision and cueing to decisions and complete task. However, R7's psychosocial notes had no documentation of a current Community Survival Skills Assessment, and Functional Skill Assessment since January of 2011. During all days of the surveyor, R7 was observed walking around the facility and not engaged in any psychosocial groups or skills training. On 9/21/2011 at 2:15 PM, R7 was interviewed in his room. R7 was noted to be alert and oriented. When asked, R7 stated he did not attend any psychosocial groups, he walked around the facility all day and was bored. R7 stated, "I would like to start doing something. I want to do a little more for group. We use to have a men's group." R7 also said he had a history of drinking and using drugs, but the facility had no drug rehab program. The last time R7 reported drinking was in May of 2011. At that time, R7 said he was	F 406		

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F 406	Continued From page 44	F 406		

caught drinking, while out on a community pass, and his community passes were revoked.
Since May of 2011, R7 stated he was not allowed outside of the facility independently and no one was helping him to get back his independent community pass. R7 complained: "I want to get out for walks."

E12 (director of social services) was interviewed on 9/21/2011. E12 reported that R7's community passes were restricted and he was not allowed out of the facility independently. E12 stated this occurred in January or February of 2011 because R7 was drinking, while out on community pass. When asked, E12 reported it was a few weeks ago (on 8/09/2011) that she spoke with the nursing staff about getting R7's community passes back. R7 told E12 he wanted to leave for walks and obtain basic need products without assistance. E12 could not provide any other evidence to support psychosocial staff had been working with R7 to ensure he understood what he needed to do to regain his community passes before 8/09/2011.

When asked, E12 said she had not done any community skills assessment for R7. After reviewing R7's social service notes, E12 said the last community skill assessment and functional skill assessment done for R7 was in January of 2011. This January Community Survival Skill Assessment documented R7 could go out into the community independently. Also, E12 could not identify the individualized treatment plan/plan of care for R7's participation in the structured group.
E12 was asked if she was the PRSD. E12 reported she was the director of social service,

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F 406	Continued From page 45 but not the PRSD. On 9/22/11 during a Meeting with administrative staff (E1/administrator and E2/director of nursing), the survey team expressed concerns the eight residents identified with serious mental illness were not appropriately assessed for participation in psychosocial groups/rehab program. Also, E1 and E2 were informed of concerns R7 and R21 were not being provided with psychosocial services that allowed the residents to maintain/improve their skills to be independent in the community. E1 and E2 provided evidence E12 could act as the PRSD. However, E1 nor E2 provided evidence the duties of the PRSD were perform by E12. Duties not performed by E12 included ensuring the facility's psychosocial programs were being effectively implemented for residents. As of exit date of 9/27/11, E1 nor E2 provided any evidence residents were appropriately assessed for participation in their weekly psychosocial groups, not appropriately assessed for drug rehab, or services to regain access to the community passes. 3. R21 was interviewed on 9/22/11 in his room at 10:30am. R21 is identified with depression, seizures , bipolar disorder, asthma, suicidal ideation, alcohol abuse and suicidal ideation on his care plan of 7/5/11. R21 said he is not allowed to go out in the community because he did get alcohol the last time he went out and he is restricted. R21 said he would like to go to A.A. and used to walk there. R21 said he does not do much of anything during the week, he likes to	F 406		

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F 406	Continued From page 46 watch TV in his room. The facility does not have any in-house groups for residents, but does contract with a psychotherapy group that provides groups on Saturdays. R21 did attend a 45 minute session on the past Saturday 9/17/11 on symptom management and re-motivation. A social service note given to surveyors regarding R21 indicates a substance abuse/ alcohol program will be located, R21 would attend and complete the program. He then would be administered a drug test and be assessed for community survival skills. If findings are negative then R21 would regain community pass and restriction will be revoked.	F 406		
F 514 SS=F	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility	F 514		10/28/11

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F 514	Continued From page 47 failed to ensure resident records were complete, accurate, and readily accessible. This is for 24 of 24 residents sampled. (R1 through R24 and R91) Findings include: This facility utilizes computerized records in the care of it's residents. During the first two days of the survey, 9/20/11 and 9/21/11, the facility's Administrator, E1, informed the surveyors that access to resident records could only be obtained by asking for copies of specific sections of the medical records. When the copies requested by the surveyors were presented by the facility, they were incomplete which required the surveyors to frequently request additional portions of the records or to request the same records a second time. These inaccuracies also required the return, several times, of CMS forms for submission of corrected information It was not until 5:30PM on 9/21/11 that the surveyors were informed that they would be given access to the facility's computer system and the user codes were not presented to surveyors until after lunch on the third day,9/22/11. On 9/20/11 after the initial tour of the facility the survey team started reviewing resident records. The team was informed by E1 (Administrator) that a lot of resident information is computerized such as MDS's, CAAS, nurses notes, dietary notes, social service notes etc... E1 also informed the team that the team would not have access to facility computers. The team then	F 514		

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F 514	Continued From page 48 asked for resident information to be printed for review. On 9/21/11 the team received a stack of printed information requested. Review of the information received showed the information presented was not complete or accurate. Sections of of the MDS was missing on many residents. The CAAs were either missing or incomplete. Nurses notes, dietary notes, social service notes were not identified making it hard/impossible for surveyors to know what discipline had documented on the notes. Review of the CAA summary sheet showed for many residents care areas were triggered but no date or location of the CAA information was identified. On 9/22/11 (third day of survey) E1 informed the surveyors they could have access to the facility's computers. Review of incident/accident reports showed no tracking log so all incidents had to be reviewed individually. Review of individual incidents showed conflicting information regarding resident dates and time of occurrence and resident injury. A list presented for residents receiving dialysis was not accurate. Three residents who received dialysis was not included on the list (R2, R9, and R91). The failure to maintain complete, accurate, and accessible records along with surveyors not having access to the facility's computers hindered the survey process. Interview with E1 on 9/22/11 regarding incomplete/inaccurate resident records noted E1	F 514		

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F 514	Continued From page 49 to say, "Our machine broke. What else do you want?" No other explanation was given.	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.4020a) 300.4030b) 300.4030c) 300.4030d)2) 300.4030l) Section 300.4020 Reassessments for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S a) At least every three months, the PRSC shall document review of the resident's progress, assessments and treatment plans. If needed, the PRSC shall inform the appropriate IDT members of the change in resident's condition. The appropriate IDT member will reassess the individual and update the resident's assessment, assuring the continued accuracy of the assessment. Section 300.4030 Individualized Treatment Plan for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S b) An ITP shall be developed within seven days after completion of the comprehensive assessment.	F9999		

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F9999	Continued From page 50 c) The plan for each resident shall state specific goals that are developed by the IDT. The resident's major needs shall be prioritized, and approaches or programs shall be developed with specific goals, to address the higher prioritized needs. If a lower priority need is not being addressed through a specific goal or program, a statement shall be made as to why it is not being addressed or how the need will be otherwise addressed. d) The ITP shall contain objectives to reach each of the individual's goals in the plan. Each objective shall: 2) Be based on the results obtained from the assessment process; l) The ITP shall be based upon each resident's assessed functioning level, appropriate to age, and shall include structured group or individual psychiatric rehabilitation services interventions or skills training activities, as appropriate, in the following areas: 1) Self-maintenance; 2) Social skills; 3) Community living skills; 4) Occupational skills; 5) Symptom management skills; and 6) Substance abuse management. Based on observation, interview and record review the facility failed to: (1) provide individualized services for residents who have serious mental illness (SMI) as	F9999		

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F9999	Continued From page 51 determined by a comprehensive assessment and to assist residents in achieving as much independence as possible. (2) re-evaluate, develop, implement and coordinate Psychiatric Rehab Service (PRS) programs and/or drug and alcohol abuse rehab services This failure effects 4 residents (R2, R6, R7, R21) in the sample of 24 and 4 residents, (R40, R71, R107 and R109) in the supplemental sample who were identified with serious mental illness. Findings include; 1. During the survey, the administrator (E1) identified 8 residents with having a severe mental illness: R2, R6, R7, R21, R40, R71, R107, R109. This list also documented that all the resident attended the same psychosocial groups on Saturdays. When asked, E1 stated that the facility only offered two psychosocial groups on Saturdays. E1 said both groups were open to any residents. But, E1 did not identified the individual therapeutic needs or goals for R2, R6, R7, R21, R40, R71, R107 or R109 to participate in this weekly psychosocial rehab program. Review of R2, R6, R7, R21, R40, R71, R107 and R109's Pre Admission Screening/ Mental Health Screening documented the above residents had a history of Severe Mental Illness and psychosocial rehab programing was indicated. 2. Review of R7's Admission Face Sheet documented that R7 is a 41 year old male with a diagnosis of serious mental illness such as:	F9999		

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F9999	Continued From page 52 Schizoaffective, Depressive Disorder, and Alcohol Intoxication. Review of R7's Physician Order Sheet documented that R7 is being treated with the following psychoactive medications: Fluoxetine 20 mg every morning Seroquel 100 mg at every night at bedtime Trazodone 50 mg every night at bedtime Seroquel 50 mg twice a day Review of R7's POS also documented that he : "May Go Out on Pass with Meds and Instruction." Review of R7's psychosocial notes documented that he had problems with feelings of depression, staying up at night, noncompliance with psychosocial and drug rehab programs, needing supervision and cueing to decisions and complete task. However, R7's psychosocial notes had no documentation of a current Community Survival Skills Assessment, and Functional Skill Assessment since January of 2011. During all days of the surveyor, R7 was observed walking around the facility and not engaged in any psychosocial groups or skills training. On 9/21/2011 at 2:15 PM, R7 was interviewed in his room. R7 was noted to be alert and oriented. When asked, R7 stated that he did not attend any psychosocial groups, he walked around the facility all day, and was bored. R7 stated, "I would like to start doing something. I want to do a little more for group. We use to have a men's group." R7 also said he had a history of drinking and using drugs, but the facility had no drug rehab	F9999		

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F9999	Continued From page 53	F9999		

program. The last time that R7 reported drinking was in May of 2011. At that time, R7 said that he was caught drinking, while out on a community pass, and his community passes were revoked.
Since May of 2011, R7 stated he was not allowed outside of the facility independently, and no one was helping him to get back his independent community pass. R7 complained: "I want to get out for walks."

E12 (director of social services) was interviewed on 9/21/2011. E12 reported that R7's community passes were restricted and he was not allowed out of the facility independently. E12 stated this occurred in January or February of 2011 because R7 was drinking, while out on community pass. When asked, E12 reported it was a few weeks ago (on 8/09/2011) that she spoke with the nursing staff about getting R7's community passes back. R7 told E12 he wanted to leave for walks and obtain basic need products without assistance. E12 could not provide any other evidence to support that psychosocial staff had been working with R7 to ensure he understood what he needed to do to regain his community passes before 8/09/2011.

When asked, E12 said she had not done any community skills assessment for R7. After reviewing R7's social service notes, E12 said the last community skill assessment and functional skill assessment done for R7 was in January of 2011. This January Community Survival Skill Assessment documented that R7 could go out into the community independently. Also, E12 could not identify the individualized treatment plan/plan of care for R7's participation in the

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F9999	Continued From page 54	F9999		

structured group.
E12 was asked if she was the PRSD. E12 reported she was the director of social service, but not the PRSD.

On 9/22/11 during a Meeting with administrative staff (E1/administrator and E2/director of nursing), the survey team expressed concerns that the eight residents identified with serious mental illness were not appropriately assessed for participation in psychosocial groups/rehab program. Also, E1 and E2 were informed of concerns that R7 and R21 were not being provided with psychosocial services that allowed the residents to maintain/improve their skills to be independent in the community. E1 and E2 provided evidence that E12 could act as the PRSD. However, E1 nor E2 provided evidence that the duties of the PRSD were perform by E12. Duties that were not performed by E12 included ensuring the facility's psychosocial programs were being effectively implemented for residents. As of exit date of 9/27/11, E1 nor E2 provided any evidence that residents were appropriately assessed for participation in their weekly psychosocial groups, not appropriately assessed for drug rehab, or services to regain access to the community passes.

3. R21 was interviewed on 9/22/11 in his room at 10:30am. R21 is identified with depression, seizures , bipolar disorder, asthma, suicidal ideation, alcohol abuse and suicidal ideation on his care plan of 7/5/11. R21 said that he is not allowed to go out in the community because he did get alcohol the last time he went out and he is restricted. R21 said he would like to go to A.A.

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F9999	Continued From page 55 and used to walk there. R21 said he does not do much of anything during the week, he likes to watch TV in his room. The facility does not have any in-house groups for residents, but does contract with a psychotherapy group that provides groups on Saturdays. R21 did attend a 45 minute session on the past Saturday 9/17/11 on symptom management and re-motivation. A social service note given to surveyors regarding R21 indicates that a substance abuse/ alcohol program will be located, R21 would attend and complete the program. He then would be administered a drug test and be assessed for community survival skills. If findings are negative then R21 would regain community pass and restriction will be revoked. (B) 300.1210a) 300.1210b) 300.1210d)1)2)3) 300.1630b) 300.3240a) Section Section 300.1210 General Requirements	F9999		

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F9999	Continued From page 56 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 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: 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: 1) Medications, including oral, rectal, hypodermic,	F9999		

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intravenous and intramuscular, shall be properly administered.
2) All treatments and procedures shall be administered as ordered by the physician.
3) Objective observations of changes in a resident's condition, including mental and 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 300.1630 Administration of Medication

b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available, a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility.

Section 300.3240 Abuse and Neglect

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

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Based on observation, record review and interview, the facility failed to:
1) Assess and implement interventions to address pain, and
2) Evaluate and modify approaches for pain when interventions were ineffective. This is for 2 residents (R1 and R9) in a sample of 24.

These failures resulted in R1 experiencing frequent episodes of avoidable pain due to ineffective management and R9 experiencing frequent pain without evaluating the effectiveness of the interventions. .

Findings include:

1. On 9/20/11, during the initial tour R1 was observed crying, groaning and complaining of pain. R1 complained to E3 (nurse) that she had pain. E3 administered Morphine Sulfate 0.5 ml via G tube to R1 without assessing the severity or location of the R1's pain.

On 9/21/11 R1 was observed lying in bed. R1 stated that she was still in pain. R1 stated "the pain is in my abdomen." On a scale of 1 - 10 R1 rated the pain at a "10."

During an interview on 9/21/11 at approximately 11:30 AM, E23 (nurse) stated that R1 receives her pain medication every 6 hours, and that R1 had her last dose at 8:00 AM.

Review of the Medication Administration Record (MAR), verified R1 received the pain medication at 8:00 AM, but R1 also had other pain

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medication ordered. E23 had not re-assessed R1 to ensure the pain medication was effective nor did E23 offered additional pain medication to decrease R1's level of pain.

Review of R1's Physician Order Sheet (POS) showed orders for the following pain medications: Morphine Sulfate 15 mg po (by mouth) every 8 hours, Morphine Sulfate 15 mg every 6 hours prn (as needed)Duragesic patch 25 mcg topically every 72 hours, Lidoderm Patch , 1 patch topically to back and change daily on 12 hours and off 12 hours.
Neither Nurses Notes nor MARs for August, 2011 and September, 2011 consistently document the severity of R1's pain when medications where administered. Nor is there documentation of the Lidoderm patch having been applied as ordered.

R1's care plan for pain listed interventions such as "note characteristics of respirations, instruct to rate pain if she can on a scale from 1-10 ...document pain level, administer pain meds, monitor/record med effectiveness, and side effects. Teach pain relievers: massage/ice exercise...assess for pain, response to pain medication/prn use or need to adjust dose and discuss with MD".
None of these listed interventions were followed on a consistent basis, nor were other interventions initiated when the current interventions were ineffective.

Review of R1's Controlled Drug Form for August,2011-Sept, 2011 documented the frequent administration of Morphine Sulfate Solution 0.5 ml (10 or 15 mg) sublingually every 2

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hours as needed for pain or air hunger. This medication was administered 50 times between 8/9/11 and 9/24/11.
Further review of R1's POS revealed that there was no order for the Morphine Sulfate to be administered every 2 hours. As noted above, R1 had physician's orders for 15 mg. to administered every 8 hours or every 6 hours PRN (as needed). During an interview with E2 (DON), regarding the discrepancies of the Morphine Sulfate administration, E2 stated "That was an error, I was hoping that you would not catch that."

Review of nursing documentation did not indicate that R1 was assessed for break through pain or alternative interventions in an attempt to minimize her pain.

2). Current physician's orders for 9/2011 shows R9 has diagnoses which includes cancer with metastasis. Nursing documentation shows R9 frequently complains of pain. The physician orders show that R9 has pain medication ordered and is on hospice.

Review of the MAR and Nurses notes verified that nurses do not consistently document R9's location, characteristic, or severity of pain. According to the MAR, R9 received Norco 325/7.5 mg for pain on 8/25/11. Nurses notes for the day do not mention R9 having pain. There is also no documentation of location, characteristics or severity of R9's pain.

According to the August 2011 MAR, R9 again received Norco 325/7.7. Again the nurses, did not assess R9's pain

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F9999	Continued From page 61 On 9/22/11 while in R9's room with Z1, E3 entered the room. R9 told E3 that he was in pain. E3 obtained Morphine liquid and administered the morphine without assessing R9's location, characteristic or severity of pain. Review of nursing documentation showed a pattern of lack of assessment of R9's pain. The facility has also developed a care plan for R9 which addresses his pain. Interventions of : --teaching R9 pain relievers, --massage/ice /exercise, --document pain level, --note characteristics of pain, --assess the resident for pain, --response to pain medication/prn use or need to adjust dose and discuss with MD. These interventions for R9 have not be been consistently implemented by nursing staff. (B) 300.1210a) 300.1210b) 300.1210d)3)5) 300.3240a)	F9999		

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F9999	Continued From page 62 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 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: 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	F9999		

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F9999	Continued From page 63 resident's condition, including mental and 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. 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 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, record review, and interview the facility failed to: 1. Prevent 1 resident (R10) from developing a stage III pressure sore while in the facility. 2. Provide descriptive documentation and develop a plan of care for 1 resident's pressure sore (R15). 3. Assess the nutritional status for 1 resident's pressure sore (R15). As a result of this failure R10 acquired a painful	F9999		

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stage III pressure sore to the coccyx.

This is for 2 residents in the sample of 24. (R10 and R15)

The findings include:

1. Review of R10's admission face sheet and current physician's orders (Sept. 2011) showed R10 was admitted to the facility on 7/6/11 with diagnoses including Acute Respiratory Failure with Tracheostomy, MRSA (methicillin resistant staph aureus), and Hypertension. Nursing documentation showed R10 has history of depression and suicidal ideations. Observation of R10 on 9/20/11 showed R10 also has a gastrostomy tube and an indwelling catheter.

Review of the facility's Pressure Sore Log showed R10 acquired a stage II pressure sore to the coccyx at the facility on 8/30/11 which measured 2.0 cm x 2.4 cm at this time.

On 9/22/11 at 10:20 a.m. E11 (RN - Wound Nurse) was observed performing treatment to R10's coccyx pressure sore with E13 and E14 (CNA's) providing standby assist. E11 removed R10's old dressing. R10's coccyx site remained open with yellowish tissue and slight thin serous drainage. The coccyx site was now 2 sites which was connected by a "skin bridge." The larger site measured 1.6 cm x 1.0 cm. The smaller site measured 1.0 cm x 0.4 cm. Interview with E11 at this time noted E11 to say R10's coccyx pressure sores now are stage III's. Observation of the sites noted both sites to be at stage III. Pressure sore log documentation dated 9/18/11 (4 days prior) for R10's coccyx site showed R10's site

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F9999	Continued From page 65 staged as a stage II with measurements at that time being 1.7 cm x 1.8 cm x 0.1 cm. Observation of R10's pressure sore on 9/22/11 showed R10's pressure sore has divided into 2 pressure sores and have worsened to stage III's. During the pressure sore treatment R10 was observed pulling away and complaining of pain when E10 touched the pressure sore site. During interview with E11 on 9/22/11, E11 was questioned why R10 developed the pressure sore to the coccyx. E11 stated, "R10 won't stay on his side. We try to prop him over with pillows but he won't stay over." No other reasons were given and no other interventions to keep R10 off of his back were mentioned. Observation of R10's right heel during the pressure sore treatment noted R10's right heel to be reddened, but blanchable. R10 had no boot/heel protector on while in bed and no intervention for heel boot/heel protector addressed on his plan of care. Review of R15's admission face sheet showed R15 has had multiple admissions and discharges from this facility. R15 was readmitted to the facility on 6/1/11. Nursing documentation of 7/3/11 contains the first mention of R15 having a pressure sore on the coccyx and right lower buttocks. On 7/11/11 staff documented R15 had an open area on the left mid buttocks; no measurements were given.	F9999		

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F9999	Continued From page 66 E11 (Treatment Nurse) was interviewed regarding R15. As stated by E11, R15's pressure ulcers started off as excoriation on her buttocks due to diarrhea, which was treated. From this R15 developed a small open area on the coccyx, stage 2. When E11 was asked about pressure sore documentation, E11 stated, "Descriptive documentation of wounds and pressure sores can be located in the nurses notes." Review of nurses notes for R15 showed the documentation of the pressure sores/open areas was not clear or consistent. There was no clear documentation of the appearance of R15's open areas/pressure sores, nor was there descriptive documentation regarding the size, depth, surrounding tissues etc... Review of dietary notes showed there was no appropriate nutritional assessment for R15. In the dietary note of 7/7/11 dietary staff wrote that R15's skin was intact. Nursing documentation showed R15 had an open area on the coccyx and on the right lower buttock at this time. Review of R15's plan of care showed no care plan was developed to address the presence of R15's multiple pressure sores and open areas. (B) 300.1210a) 300.1210b)2)	F9999		

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F9999	Continued From page 67 300.1210d)2) 300.3240a) 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 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:	F9999		

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F9999	Continued From page 68 2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. 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. 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 observations, interviews and record review, the facility failed to ensure that one resident (R18 in a sample of 17 residents with concerns for limited range of motion.) received all the appropriate services to ensure that the resident's ROM (Range of Motion) did not decline.	F9999		

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F9999	Continued From page 69 This failure resulted in R18 experiencing a decline in ROM within the three months that he resided in the facility. Findings include: Review of R18's Admission Face Sheet documented that R18 is a 54 year old male with diagnoses including Cardiovascular Accident with Right Hemiplegia. R18 was admitted to the facility on 5/06/2011. Review of R18's Physician Order Sheet documented the following interventions for R18: "Right hand splint while up in wheel chair; off for direct care." Review of R18's Initial Restorative Nursing Assessment, dated 5/07/2011 at 6:19 PM, documented the following ROM for R18: Right fingers = normal mobility, right elbow = normal mobility, right wrist = normal mobility, right hip = normal mobility, right knee and ankle = normal mobility. Review of R18's most recent Restorative Nursing Assessment, dated 8/15/2011 at 6:15 AM, documented the following decline in ROM for R18: right fingers = "Severe, less than 50% normal mobility", right elbow = "Severe, less than 50% normal mobility", right wrist = "Severe, less than 50% normal mobility", right hip = "Severe, less than 50% normal mobility, and right knee = "Severe, less than 50% normal mobility, and right ankle = "Severe, less than 50% normal mobility". Review of the flow sheet used to record	F9999		

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"Restorative All shift" care, dated from June/2011 to September 2011, did not document facility's staff providing consistent restorative services to R18. Several days each month were left blank without any documentation indicating why. A majority of the documentation recorded R18 only wearing his right hand splint for 15 minutes.

On 9/20/2011 1:30 PM to 2:30 PM, 9/22/2011 10:10 AM and 11 AM, and 11:30 AM R18 was observed sitting in the day room in his wheel chair without his splint being applied to his right hand or any device/position to prevent contractures to his right leg and ankle. When interviewed on 9/22/11 at 11:30 a.m., R18 stated he could only open the fingers of his right hand with help; that he couldn't open them spontaneously. R18's right hand was slightly contracted and his entire right arm was flaccid. Immediately prior to the interview, R18's right hand splint was obseved laying on the top of his bedside table.

On 9/22/2011 and 9/24/2011, R18 was interviewed in his room and day room. R18 was observed to be alert and talkative. When asked R18 stated "staff did not always put on his right hand splint, or do daily ROM exercises." R18 expressed his fears that he was loosing the use of his right hand, and staff were not providing him with the care he needed.

On 9/24/2011, the restorative certified nurse aide (CNA) was observed in R18's room. E10 (restorative aide) reported that R18 was admitted to the facility in the middle of March 2011, and had experienced a decline since being admitted. E10 stated "R18's right elbow and right knee has become more contracted since admission."

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F9999	Continued From page 71 When asked, E10 said she did not know why R18 has decline in ROM. On 9/24/2011 at 10:05 AM, the restorative nurse was interviewed. E11(restorative nurse) stated that R18's initial restorative assessment was done on 5/07/2011. The goal was to increase R18's ROM by 8/17/2011. E11 was asked to review R18's admission nursing restorative notes dated 5/07/2011 and most recent nursing restorative noted dated 8/11/2011. After reviewing R18's admission restorative assessment and the current restorative nursing assessment, E11 stated that R18 had decline in the following areas: right elbow, right wrist, right hip and right knee. When asked, E11 said she did not know why R18 was declining in ROM. While reviewing R18's restorative care plan and documentation of care, E11 could not tell why some days were left blank. When asked was it appropriate to apply R18's splint for only 15 minutes, E11 replied, "R18 required more than 15 minutes for his splint to be effective." E11 could not give any reasons why R18 had a decline in ROM. E11 also could not identify any changes that were done to R18's restorative program to prevent further decline in R18's ROM. During a meeting with the facility's administrative staff (administrator/E1 and director of nursing/E2), on 9/22/11, the surveyor team expressed concerns that R18 was not receiving the appropriate care to prevent decline in his ROM. Up to date of exit on 9/27/2011, E1 nor E2 provided any evidence to support that R18 received the appropriate services and consistent care needed to prevent decline in ROM.	F9999		

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F9999	Continued From page 72 (B) 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)6) 300.3240a) 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	F9999		

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F9999	Continued From page 73 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 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: 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 seethat 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.	F9999		

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Based on observation, record review, and interview the facility failed to:

1. Provide supervision to residents to prevent falls, serious injuries, and/or fractures. This occurred for 4 of 24 sampled resident (R10,R17,R19 and R20) and 4 residents in the supplemental sample. (R26, R86, R138, R91).
2. Provide supervision and develop effective interventions to prevent residents in the sample with tracheostomies from consistently extubating themselves. (R10 and R19).
3. Develop, implement, and maintain a system to track residents' falls, failed to identify the circumstances why falls occurred, and failed to analyze patterns and trends of falls and incidents occurring at the facility.

As a result of these failures:

1. R26 had 3 falls from 7/25 to 8/8/11 and sustained a fracture to his lumbar spine.
2. R86 had 2 falls on 7/10 and 8/14/11 and sustained a closed head injury and fracture to the left shoulder.
3. R138 had a fall on 8/27/11 and sustained a fracture to the left hip.
4. R91 was injured while being transferred to bed and on 8/4/11 hospital documentation showed R91 had sustained a torn meniscus and fracture to the left knee.
5. R20 had several falls and incidents and sustained a bruise to his back.
6. R10 was noted to have extubated himself 13 times from 7/13 to 9/19/11.
7. R19 was noted to have extubated himself 3

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times from 7/18 to 8/2/11.
8. R17 fell twice within two days of admission to the facility, hit her head on the second day of admission and was admitted to an area hospital, to the Intensive Care Unit with diagnoses of head injury and intracranial bleed.

The findings include:

1. Review of R26's admission face sheet showed R26 has diagnoses which includes Cerebral Vascular Accident, Hypertension, and Coronary Artery Disease. Nursing documentation showed R26 had history of falls.

During review of the facility's incident reports R26 was noted with 3 incidents/falls from 7/25/11 to 8/8/11. Incident documentation showed on 7/25/11 at 9:40 a.m. R26 attempted to transfer himself from the toilet back into his wheel chair and fell. Incident documentation showed R26 started complaining of severe back pain on 7/27/11 and was sent to a nearby hospital for evaluation. R27 was admitted to the hospital with diagnosis of fracture to the lumbar spine. Review of CT (computerized tomography) from the hospital dated 7/27/11 showed the following:

R26 had a "moderate to marked compression fracture of the L1 vertebral body which does have a diffuse increased density. This may be possibly subacute in nature. There is, however a question of some mild paraspinal soft tissue edema at this level which could have a recent component associated with it There is a faint line projected through the right-sided posterior margin of the L1 vertebral body with the pedicle consistent with a

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non displaced fracture line at this level. "

The CT scan also showed R26 "had slight wedging of the L2 and mild loss of height of the L3 vertebral body with mild impressions noted in the endplates at L4 and L5. Varying degrees of disc space narrowing noted, most pronounced at L5-S1."

R26 was readmitted to the facility on 8/3/11. Nursing documentation showed R26 complained of moderate pain during therapies and during care. Nursing documentation also showed R26 MUST WEAR BACK BRACE WHEN UP. Review of R26's plan of care for falls presented with the incident follow up report showed no intervention for R26 to wear his back brace. The follow up report notes, "Facility will continue to monitor and provide safety according to Plan of Care."

Nursing documentation and incident documentation showed R26 had a fall in his room on 8/6/11 and a fall in the bathroom on 8/8/11. Documentation for the fall of 8/8/11 showed R26 put himself on the toilet, fell back against the toilet tank completely breaking the tank. R26 was sent back to the hospital for x-rays and admitted to to the hospital with diagnosis of TIA (trans ischemic attack). R26 was readmitted to the facility again on 8/11/11.

Observation of R26 9/23/11 at 10:20 a.m. noted R26 to be sitting in his electric wheel chair in the second floor dining room. R26 was noted with a Velcro wrap back support in place. Interview with R26 at this time noted R26 to say, "I think that I fell out of bed when I fractured my back. The second time when I fell and had to go to the

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hospital I was trying to go to the bathroom. I don't remember what happened."

As mentioned above; review of R26's plan of care addressing falls showed no intervention which included wearing a back brace. There was no description of R26's back brace and no instructions on how the brace is to be applied. The fall plan of care showed no intervention for more frequent observation of R26 in an attempt to try to prevent further falls/injuries. The fall plan of care showed an intervention that R26's room should be moved closer to the nurses station. R26's room was observed to be approximately half way down the hallway where he resides.

2. Review of incident reports for R86 showed on 7/10/11 R86 was in the bathroom, got dizzy, fell, and hit his head on the toilet. R86 was sent to a nearby hospital where he was admitted with diagnoses of closed head injury. Incident reports showed on 8/4/11 R86 again fell in his bathroom while toileting and complained of pain to the right ankle. Nursing documentation showed R86 experienced pain "if he tried to walk." Further nursing documentation showed R86 had NO HISTORY OF FALLS (PAST 3 MONTHS) even though R86 had fallen on 7/10/11 (approximately 3 weeks prior) and sustained a closed head injury.

Further review of incident reports showed on 8/14/11 at 2:30 PM R86 reported he had fallen in his room while transferring back to bed. R86 complained of pain to the left shoulder. Stat x-rays were taken of R86's left shoulder with results which showed "Non displaced fracture of the greater tuberosity and suspicious fracture of

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the neck of the left humerus." R86 was admitted to the hospital with diagnosis of Hypotension. On 8/14/11 R86's blood pressure at 4:15 p.m. was documented at 108/68. R86's plan of care addressing falls includes "monitor for any evidence of hypotension."

3. Review of R138's closed record and incident report dated 8/27/11 showed conflicting information on the incident report and nurses notes. The incident report dated 8/27/11 showed time of occurrence at 11:00 p.m. and noted during rounds the nurse found R138 on the floor. Review of nursing note documentation showed on 8/27/11 at 5:15 p.m. R138 fell in his room while transferring to a chair. Nursing documentation showed NO APPARENT INJURY even though skin tears were documented and x-ray of the left hip and femur were ordered. Initial facility x-rays of the left hip and femur were negative. Facility incident report goes on to note R138 saw an outside physician on 9/2/11 and was found to have a hairline fracture of the greater trochanter.

Review of a hospital x-ray dated 8/30/11 showed R138 was identified with a left hip fracture on 8/30/11 not 9/2/11. The hospital x-ray showed "There appears to be fragmentation and slight linear lucencies extending through the greater trochanteric of the left femur. Configuration raises the possibility of cortical fractures about the greater trochanter left femur."

Further review of nursing documentation for R138 showed on 8/26/11 at 11:00 p.m. R138 fell in his

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room while transferring to bed. At this time R138's blood pressure was noted at 94/66. On 8/27/11 at the time of R138's fall his blood pressure was documented at 100/58. No plan of care was presented to address R138's hypotension and prevention of falls.

4. Review of an incident report for R91 and interview with E2 (Director of Nurses) showed conflicting information. Incident report review showed R91 had an incident (date unknown) while being transferred to bed R91's knee was hit on the bed frame. Incident documentation showed R91 stated this happened one week before she was hospitalized on 8/4/11. Review of the incident follow-up report dated 8/17/11 showed R91 returned to the facility on 8/16/11, had follow up appointment in 1 week with ortho, and had no change in functional status.

On 9/22/11 at approximately 2:30 p.m. E2 (Director of Nurses) was questioned regarding the incident with R91 bumping her knee while being transferred to bed. E2 stated R91 went to the hospital for a medical problem and they checked her knee there. E2 stated, "R91 didn't have any fracture, she had an effusion."

On 9/23/11 at 11:00 a.m. R91 was observed receiving dialysis in the facility's dialysis unit. R91 was alert and verbally responsive. During interview with R91 at this time about the incident with bumping her knee R91 started, "I have an electric wheel chair. When the CNA was putting me to bed she didn't turn off the wheel chair. It got away from her and it jumped and my knee hit the bed rail. It hurt bad. They did x-rays at the hospital but the MRI showed I had a hairline

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F9999	Continued From page 80 fracture and something else wrong with my knee." R91's MRI results were requested and reviewed. R91's MRI results were dated 8/8/11. Review of the results showed documentation of the following injury: Impression: 1. Tear in the posterior horn and body of the lateral meniscus. 2. Nondisplaced fracture within the lateral tibial plateau which extends to tibial spine and visualized proximal tibial shaft. The most distal aspect of the fracture component is beyond the border of these images. In addition, there is about a 2 mm impaction of the fracture along the anterior aspect of the lateral tibial plateau. During interview with R91, R91 stated, "My knee still hurts sometimes and I still have to take pain pills for the pain." Review of R91's plan of care showed no interventions regarding instructions on operating R91's wheel chair when transferring R91 to and from the wheel chair. E2 also did not note that staff had been inserviced/trained on operating R91's wheel chair to prevent further accidents. 5. Review of incident reports for R20 showed R20 had 7 falls from 4/14/11 to 9/21/11. During most of R20's falls there is documentation that R20 is in his recliner chair in his room and is found on the floor. With one fall R20 is noted with bruising on his back. Confidential interview	F9999		

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on 9/22/11 notes that R20 is usually put in his recliner chair with the feet elevated so "he can't get up." Also noted with R20's falls his blood pressures vastly fluctuates from 115/59 to 161/115.

Review of R20's plan of care shows no follow up in evaluating R20's blood pressure fluctuations in an attempt to determine R20's falls. The plan of care also does not address positioning of R10 in his recliner chair or other interventions to prevent R20 from falling out of his recliner chair.

6. Observation of R10 on 9/22/10 at 10:20 a.m. noted R10 to be resting in bed. R10 was observed with a tracheostomy in place connected to a trach cuff and oxygen at 5L/min. R10 was in contact isolation for MRSA (methicillin resistant staph aureus). R10 also had a gastrostomy tube, and an indwelling catheter. Nursing documentation dated 7/22/11 on the CAA's (care area assessments) showed R10 has history of depression and has voiced suicidal thoughts.

Review of nursing documentation from 7/13 to 9/19/11 showed R10 had pulled his tracheostomy tube out 13 times. During some of the times R10 had extubated himself, he had also pulled out and/or pulled on his gastrostomy tube and indwelling catheter. R10 was observed to be wearing hand mitts on 9/22/10. Review of R10's plan of care showed interventions that R10 had hand mitts ordered at times and wrist restraints ordered at other times. On 8/18 and 8/22/11 R10 also had an intervention for R10 to be monitored every 30 minutes. Review of nurses notes showed R10 had extubated himself 6 times after the intervention was developed to monitor him

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every 30 minutes.

No other successful interventions were addressed/developed to prevent R10 from pulling on his tracheostomy to prevent him from extubating himself or from pulling on his gastrostomy tube and indwelling catheter.

During interviews with E1 (Administrator) and E2 (Director of Nurses) on 9/23/11 both admitted that the facility does not keep a tracking log to track individual resident's falls/incidents. Both admitted the facility has no Fall Committee to address resident falls and both admitted no one is analyzing or identifying the circumstances for why the falls are occurring. The facility is not identifying whether there are fall patterns and/or trends of resident falls and incidents.

E1 and E2 did present Incident/Accident Report Summaries for July and August 2011. These reports showed numbers and data collection but no individual analysis or summary of conclusion to identify an individual decrease in falls/incidents for any resident. Further review of these summaries showed they were not accurate/complete. The July 2011 summary sheet included a section identifying "Residents involved in more than one (1) incident this month." This section had initials of residents who had more than 1 incident in July. R20 had 2 documented falls in July. R20's initials were not included on this summary sheet.

7. Review of R19 Admission Face Sheet document R19 is a 73 year old male with

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diagnosis including: Generalized Muscle Weakness, Acute Respiratory Failure, Intermittent Confusion, and History of Neck Fracture.

Review of R19's Nursing Notes documented that R19 pulled out his tracheostomy tube several times. The nursing notes document the the following:

7/18/2011 6:35 PM Alert, oriented to time... person... to place... staff assist needed... pulls at tubes at time...has difficulty making decision in new situation.
6:44 PM Level of Consciousness/Mental Status Intermittent Confusion, chair bound, legally Bind...
9:30 PM Called to resident's room, has pulled out trach tube.
Reinserted... small amount of bleeding noted."

7/19/2011 12:35 PM Decreased range of motion. Decline in muscle strength. Resident restrained for: behavioral symptoms: trying to pull out tracheostomy tube. Restraint prevented behavior from occurring. Contributing problems: confusion... Use bilateral mitts at all times... Resident has a life threatening condition..."

7/21/2011 11:11 PM Pulled out trach from site... Interventions: transferred to emergency room..."

7/27/2011 12:05 AM... Trach out... Resident room...Resident in bed"

R19's Nursing Notes also documented that R19 had 7 falls between 7/18/2011 to 8/25/2011. The nursing notes documented that R19 fell on the following days: 7/18/2011, 7/21/2011, 7/27/2011,

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F9999	Continued From page 84 7/31/2011, 8/02/2011, 8/17/201, 8/21/2011, 8/22/2011 and 8/25/2011. The facility incident report that documented R19 pulling out his trach and falling on 7/21/2011 was reviewed. This was after R19 demonstrated he was confused and had exhibited the behavior of pulling out his tracheostomy tube. Staff interviews documented that they walked into R19's room around 7 PM and noticed R19's trach was out. Staff stated R19 could remove his mitts. Also, all staff interviewed noted that they last observed R19 approximately an hour ago (5:30 PM or 6:15 PM). This indicated R19 was not being closely monitored for the behavior of extubating himself. On 9/22/2011 at 10 AM, E9 (nurse) was accompanied to R19's room to observe what interventions were in place to prevent R19 from falling. E9 stated that R19 was at risk for falls. E9 also stated R19 had mats on the floor, boosters in the bed, and chair and bed alarms to prevent him from falling. However; R19 was observed in his wheel chair, sitting alone in his room, with no chair alarm attached. When asked about the absence of the chair alarm, E9 stated R19 should have one. R19 stated he did not need the chair alarm. The CNA for R19 entered the room. When asked about the absence of R19's chair alarm, the CNA stated, "R19 told me not to put it (chair alarm) on." This showed the nursing interventions identified to prevent R19 from falling were not being consistently implemented. E21 (nurse) was identified as taking care of R19 on 7/21/2011, when R19 pulled out his	F9999		

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tracheostomy tube. E21 was interviewed on 9/27/2011 at 11:39 AM. When asked, E21 stated R19 has removed his tracheostomy "a couple of times". E21 also stated, "R19 did not want it in and he pulled it out. We've had to put his trach tube back in before. A couple of times, we sent him out to the hospital to get it back in."

E22 (nurse) was identified as caring for R19 on 7/27/2011, when he removed his tracheostomy tube. E22 was interviewed on 7/27/2011 at 11 AM. E22 stated, "I went in there and it was out. At times he could get his mitts off. I just remember I went in there and it was out. I think there's been a few times he went to the hospital because it could not be reinserted".

Review of R19's plan of care addressing R19's tracheostomy showed there was no consistent and effective interventions in place to prevent R19 from pulling his trach tube out (extubating himself) to prevent bleeding and irritation to the trach tube site.

8. R17's closed record was reviewed. R17's admission face sheet showed R17 was admitted to the facility on 9/1/11 with diagnoses including Altered Mental Status, Vascular Dementia, Muscle Disuse Atrophy and Abnormality of Gait. R17 was admitted to this facility from another area nursing facility. The transferring facility sent background information about R17's illness and the course of care that R17 had received at the prior facility.

Information sent with R17 from the previous nursing facility clearly documents R17's

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dementia, inability to follow commands, poor cognition, confusion and disorientation, Cerebral Vascular Accident (CVA), and Muscular Disuse Atrophy.

E17 Certified Nursing Assistant (CNA) had been assigned to provide care to R17 during R17's short stay at the facility.
E17 described R17 as "very confused and disoriented with a contracted left leg." "R17 was not ambulatory and needed a mechanical lift to transfer."

Review of nurses notes and facility incident reports showed on 9/2/11 at 11:43PM, (the day after R17 was admitted to this facility), "R17 was found on the floor. R17's mental status post fall was assessed as "same as baseline".

On 9/3/11 R17 was found on the floor again. On this date E17 (CNA) found R17 on the floor. According to E17 on 9/3/11 while doing rounds E17 walked into R17's room and found the resident on the floor with the wheelchair behind her. R17's legs were underneath the wheelchair. R17 was not unconscious, but was not responsive to verbal stimuli. E17 returned the resident to bed. R17 would squeeze E17's hand and look at her, but not talk. E17 stated, "This is a change in mental status from the day of R17's admission." When found on the floor R17 was bleeding from her forehead.

E17 stated she never observed R17 in the wheelchair. E17 stated, "On 9/1/11 R17 stayed in bed until therapy could assess her. On 9/2/11 I was off work and on 9/3/11 I found R17 on the floor." E17 continued to say when R17 was first

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admitted they (CNA's) were told R17 was confused and to "watch her" and to keep an eye on her. E17 stated that CNAs get report on residents, then they do rounds. E17 stated, "There was not any special information provided on R17 other than the fact that R17 was up in the chair."

E18 (nurse) also cared for R17 during her stay. E18 stated she worked 6:30AM to 3:00PM on the day that R17 was found on the floor (9/3/11) . E18 also described R17 as having contracted bilateral knees and totally dependent for mobility. Regarding R17's mental status, E18 stated R17 would only look at her, nothing more. E18 stated, "On 9/3/11 R17 was not very alert in the morning but was more alert in the afternoon. R17's son came to visit at 2:30PM and brought R17 lunch. The son was surprised at the level of R17's alertness. R17 was sitting in the wheelchair."

E18 stated R17 was cognitively and physically unable to propel herself in the wheelchair and wasn't ambulatory at all. E18 stated she had just finished report when she heard E17 say that R17 was on the floor. When E18 saw R17, R17 was laying face down on the floor bleeding from the middle of her forehead. R17 was nonverbal and looking around aimlessly. CNAs got the mechanical lift to return R17 to bed.

Facility nurses notes and fall assessment both assess R17 as having difficulty walking and with poor balance. The nurses notes and fall assessment also showed R17 as having both short and long term memory problems, severely limited ability to walk, unable to bear weight or

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communicate, being immobile, and with a wheelchair as the primary mode of locomotion. Facility staff also assessed R17 in need on one staff to transfer.

The initial fall care plan for R17 was initiated 9/1/11 and assessed R17 as high risk for falls. The listed interventions included instructions to:

1. Ask for assistance prior to attempting to transfer or walk.
2. To place the call light within easy reach
3. Encourage R17 to use the call light prior to attempting to walk or transfer.

These interventions were not realistic, but were implemented even though the facility's own staff had assessed R17 as as having difficulty walking and with poor balance, as having both short and long term memory problems, as having severely limited ability to walk, not being unable to bear weight or communicate, being immobile, and with a wheelchair as the primary mode of locomotion. R17 was also in need on one staff to transfer.

Further review of R17's incident report for 9/3/11 showed at 3:35 p.m. R17 was found on the floor with a laceration (no area specified). Incident documentation showed R17 was sent to a nearby hospital where she was admitted to the Intensive Care Unit (ICU) with diagnoses of Head Injury and Intracranial Bleed.

(B)