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	145887	A. BUILDING _____ B. WING _____	10/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAUCONDA HEALTHCARE AND REHAB	176 THOMAS COURT WAUCONDA, IL 60084

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification. VALIDATION SURVEY FOR SUBPART U: ALZHEIMER UNIT Wauconda Healthcare and Rehab is in compliance with Subpart U, 77 Illinois Administrative Code, Section 300.7000	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164		11/25/11

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

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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that residents are provided privacy when care is being given. This failure is for 1 resident (R10) in the sample of 24, and 2 residents (R25, R26) in the supplemental sample. The findings include: 1. On 10/25/11 at 9:10 AM E9 (CNA) was observed providing incontinence care to R10. E9 left R10 naked and exposed from the waste down while he went into the bathroom to obtain a wash clothe to clean the resident. E9 said that he was not aware of the need to cover the resident. 2. On 10/25/11 at 3:51 PM E10 and E11 (CNA's) were observed applying a blood pressure cuff to R26's lower leg. R26 was in bed and the door was open. The privacy curtain was not pulled. R26's pant leg was pulled up and he was viewable from the hallway. 3. On 10/26/11 at 10:35 AM Z1 (Physician) was observed examining R25 in the common area outside the dining room.	F 164		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		11/25/11

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F 241	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to promote the dignity of residents. This is for 2 residents (R15 and R16) in the sample of 24. The findings include: 1. On 10/25/11 at 3:50 PM E10 (CNA) entered R16's room without knocking and without asking permission to enter. When R16 asked E10 is she could help him, he said that he needed to take R16's vitals. On 10/26/11 at 2:20 PM R16 said that staff enter her room all the time without knocking or asking permission to enter. 2. On 10/25/11 at 9:10 AM R15 was in a wheelchair facing the wall in her room. E9 (CNA) was in the room providing care to R15's roommate. On 10/27/11 at 8:30 AM R15 was again in a wheelchair facing the wall in her room. E9 was again providing care to R15's roommate. E9 said that he placed R15 facing the wall because he needed to move her out of the way to take care of her roommate. 3. On 10/26/11 at 11:05 AM E12 (Housekeeper) was observed speaking a foreign language in the hallway (300). Residents were present in the hallway at the time. On 10/27/11 E2 (DON) said that E12 was coached on not speaking a foreign language in front of residents.	F 241		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		11/25/11

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F 309 SS=G	Continued From page 3 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 observations, interview and record review the facility failed to address a resident's poor positioning and failed to identify a rash resulting from the resident's poor position. These failures resulted in 1 resident (R15) developing a neck rash with fungus. The sample size is 24. The findings include: R15 is an 81 year old, severely cognitively impaired resident who was re-admitted to the facility on 3/15/10 with multiple diagnoses, including Parkinson's Disease, according to the most recent Minimum Data Assessment (MDS) dated 9/14/11. R15 is totally dependent on staff for bed mobility, transfers, locomotion, dressing, eating and personal hygiene, according to the 9/14/11 MDS. R15 was observed in her wheelchair with her head down and her chin touching the right side of her upper chest on 10/24/11 at 2:10 PM; 10/25/11 at 8:45 AM, 9:10 AM, 11:00 AM, 12:55 PM and 4:05 PM; and 10/26/11 at 8:45 AM, 10:05 AM, 10:20 AM, 10:41 AM and 10:55 AM.	F 309		

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F 309	Continued From page 4 On 10/26/11 at 10:55 AM E6 (Restorative Aide) said that R15 usually keeps her head down and her eyes closed. E6 lifted up R15's head slightly and held it. A deep red rash was noted in the skin folds of R15's neck. E3 (Restorative and Wound Nurse) was present at this time. E3 said that she was not aware that R15 had a rash on her neck. On 10/26/11 at 11:10 AM Z1 (Doctor) examined R15's neck. Z1 said that R15 had a rash with fungus. Z1 said that he ordered anti-fungal cream. On 12/26/11 at 12:36 PM E7 (CNA) said that she noticed that R15 had a rash on her neck in the morning but did not tell the nurse because she thought the nurse new about it. On 12/26/11 at 11:20 AM E8 (Nurse) said that she was not aware that R15 had a rash on her neck.	F 309		
F 317 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 317		11/25/11

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F 317	Continued From page 5	F 317		

review the facility failed to assess, provide interventions, and care plan to prevent limitations in range of motion to the neck. These failures resulted in the development of a severe range of motion limitation of the neck for 1 resident (R15), out of 6 reviewed for range of motion, in the total sample of 24.

The findings include:

R15 is an 81 year old, severely cognitively impaired resident who was re-admitted to the facility on 3/15/10 with multiple diagnoses, including Parkinson's Disease, according to the most recent Minimum Data Assessment (MDS) dated 9/14/11. R15 is totally dependent on staff for bed mobility, transfers, locomotion, dressing, eating and personal hygiene, according to the 9/14/11 MDS. R15 has bilateral functional limitations in range of motion of the upper extremity (shoulder, elbow, wrist, hand), and lower extremity (hip, knee, ankle, foot) according to the 9/14/11 MDS. The facility's Restorative Functional Assessment dated 9/14/11 does not assess R15's limited range of motion of her neck. Physical Therapy notes dated 1/5 - 1/12/11 document that R15 needs reminders to keep her head up and sit upright. R15's therapy discharge recommendations for restorative care dated 2/3/11 state "Encourage pts head position to be up." R15's Care Assessment Areas dated 3/18/11 does not assess R15's behavior of holding her head down. R15's care plan does not identify R15's behavior of holding her head down, and no interventions were planned.

R15 was observed in her wheelchair with her head down and her chin touching the right side of

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F 317	Continued From page 6 her upper chest on 10/24/11 at 2:10 PM; 10/25/11 at 8:45 AM, 9:10 AM, 11:00 AM, 12:55 PM and 4:05 PM; and 10/26/11 at 8:45 AM, 10:05 AM, 10:20 AM, 10:41 AM, 10:55 AM and 2:25 PM. On 10/26/11 E3 (Restorative Nurse) said that there was no prior assessment of R15's range of motion to her neck. E3 said that the restorative functional assessment does not include a section for evaluating range of motion to the neck. On 10/27/11 at 12:10 PM E3 said that R15 did not have a care plan addressing R15's behavior of holding her head down and no interventions were planned. On 10/26/11 at 1:50 PM E6 (Restorative Aide) said that R15 has been holding her head down more in the past 3 - 5 months. E6 said that R15 could previously holding her head up on her own, but now she cannot hold it on her own. E6 said "sometimes I turn her head" because she won't do it on her own. On 10/17/11 at 8:55 AM Z2 (Physical Therapist Assistant) said that when R15 was admitted in March of 2010 she din not have any neck issues according to the therapy notes. Z2 said that R15 was picked up by therapy again in January 2011 after she had a fall. Z2 said that at that time they noticed that R15 was starting to put her head down and needed cues to hold her head up and stand upright. Z2 said that no range of motion measurements were taken of R15's neck because range of motion wasn't a problem. Z2 pointed out that when R15 was discharged from therapy on 2/3/11 it was recommended that staff encourage R15 to hold her head up.	F 317		

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F 317	Continued From page 7 On 10/27/11 Z3 (Physical Therapist) completed an assessment on R15. Z3 said that R15 cannot hold her head up on her own. Z3 said that R15 has severe limits to range of motion upon left rotation of the head. Additionally, Z3 said that R15 has functional limits to range of motion to all areas of her neck. Z3 said that R15 requires proper positioning/body alignment to reduce further reductions in range of motion.	F 317		
F 323 SS=D	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 observations, interview and record review, the facility failed to provide a safe environment by not ensuring treatment cart, emergency cart, boiler room, storage area, circuit breaker electrical panel were kept locked and are not accessible to cognitively impaired residents. This deficient practice was observed in 1 of 3 nursing station units (Town Square area). This nursing unit is connected with easy access to 3 resident hallways and a lounge area. Findings include: 1) During the initial tour with	F 323		11/25/11

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F 323	Continued From page 8 E3(restorative/treatment nurse) on 10/24/2011 at 11:05 A.M., the boiler was not locked. The boiler room is adjacent to the nursing unit(Town Square unit). Inside the boiler room was an unlocked circuit electrical panel. There were also boxes of screws and light bulb on top of a maintenance cart that was found inside the boiler room. 2) On 10/24/2011 at 11:10 A.M., with E3, the (tub room) in 300 wing is use as a storage area. This storage area was not locked when observed. There was a floor polisher machine that has a long extension of an electrical cord and was dangling from the machine and was next to the unlock door. 3) On 10/26/2011 from 10:16 A.M. to 10:30 A.M., there was an unattended treatment cart that was not locked. Inside the treatment cart were multiple tubes/ containers of wound cleansing solution, cream and ointments for wound treatments. This treatment cart was in the hallway next to the Town Square nursing station. This nursing station is an open unit that is connected to resident's lounge and 3 residents's hallways. On 10/26/2011 at 10:35 A.M., E3 (restorative/treatment nurse) stated she forgot to lock the treatment cart. E3 also confirmed that there are residents who are cognitively impaired and wanders around the unit/hallway/lounge area. 4) During the environmental tour of the facility with E17 (Maintenance Director), E18 (Housekeeping Supervisor) and E19 (Maintenance Supervisor) on 10/26/11 at 11:50 AM, an emergency cart was observed outside the Town Square nursing station. On top of this emergency cart were two (2) tubes of glucagon	F 323		

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F 323	Continued From page 9 medications (emergency medication to quickly elevate blood sugar level), visible and accessible to the residents in the 100, 200 and 300 units. On 10/26/11 at 11:55 AM, E20 (Assistant Director of Nursing) stated that there are confused and mobile residents in these units.	F 323		
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility to follow the menu for puree diet types, and failed to follow the recipe when preparing pureed diets. This is for 2 of 2 residents receiving puree diets, 1 (R1) in the sample of 24, and 1 (R26) in the supplemental sample. The findings include: The facility offers multiple choice menus for all diet types according to the Spring/Summer 2011 Menu Diet Extensions. The choices for puree diet types include puree salad, puree garlic bread and puree pasta in garlic sauce. On 10/24/11 at 11:30 AM E13 (Cook) was observed preparing the pureed diet types in the kitchen. E13 did not follow any recipes when preparing the pureed diets. E13 did not prepare	F 363		11/16/11

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F 363	Continued From page 10 puree salad, puree garlic bread or puree pasta in garlic sauce. On 10/25/11 at 11:30 AM E14 (Dining Services Manager) said that the salads are not prepared for the mechanical (puree) diet types because their speech therapist said not to serve it. E14 said that no substitution was made. On 10/25/11 at 2:22 PM E15 (Food Service Director) said that he did not know why the cook did not puree the garlic bread and the pasta. E15 said that the cook should have pureed these items. E13 was observed preparing the pureed beef and vegetable soup. E13 place several cups of beef and vegetable soup in the blender and blenderized the mixture. The end product had the consistency of thin liquid. E13 did not add any thickener to the mixtures. The Puree Beef Vegetable Soup recipe states "Add thickener while processing til HONEY THICK." Two residents (R1 and R26) receive puree diets according to the facility's diet list.	F 363		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		11/16/11

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F 371	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that sanitation practices were followed in the kitchen in the areas of food preparation and storage, hand washing, cleaning and storage of dishes and utensils, and storage of pans. This failure has the potential to affect all 122 residents residing at the facility. The findings include: On 10/24/11 at 11:30 AM E13 (Cook) was observed preparing the pureed diets. E13 did not change her gloves or wash her hands after touching soiled areas, such as, the garbage and soiled pans. For example, after touching the garbage lid E13 touched the inside of a pan with her soiled glove. E13 than scooped the pureed vegetable mixture into the same pan. On 10/24/11 at 11:20 AM the facility's hot water sanitizing dish machine was not reaching the appropriate minimal wash temperature of 140 degrees Fahrenheit (F). Additionally, the facility's Dishmachine Temperature Log for October 2011 showed that the final rinse temperature failed to reach 180 degrees F on 17 occasions. No corrective action was documented on the form under the section "Action Taken if Out of Range." The facility's Dish Machine Protocol dated March 2006 documents that was temperatures should be between 155 - 160 degrees F, and final rinse temperatures should be between 180 - 195 degrees F. Additionally the policy states "Communicate any issues to manager."	F 371		

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F 371	Continued From page 12 Multiple issues were identified regarding the cleanliness of dishes, utensils and pans. For example, more than a dozen plates were found soiled with foodstuff, i.e. dried eggs, and/or flecks for debris. These plates were identified as clean and stored in the plate warming machine at the steam table. E15 (Dining Services Director) was present for this observation. The meat slicer was covered with a large black plastic bag and was identified as clean by E15. The slicer was soiled with crumbs and food flecks. All three utensil drawers were soiled with standing water and food debris that was in contact with the clean utensils in the drawer. Two of the utensils had chunks of plastic missing from them and were in poor condition. The 3-tier carts used to transport food and drink was visible soiled with food stuff. The pans stored in the clean area next to the dish machine were noted to be wet, and stacked on top of each other. E16 (Pot and Pan Washer) was observed stacking a wet container on top of other containers in the clean area. The facility's Manual Pot & Pan Wash Procedure dated March 2006 states "Turn all pans upside down or inverted and allow to air dry completely before any item(s) are placed on designated storage shelving."	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441		11/25/11

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F 441	Continued From page 13 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that staff did not contaminate clean linens and handled in the manner to prevent the potential spread of infection. This was observed in 2 of 3 resident's units in the facility.	F 441		

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	145887	A. BUILDING _____ B. WING _____	10/27/2011

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F 441	Continued From page 14 Findings include: 1) During the initial tour with E3(restorative/treatment nurse) on 10/24/2011 at 10:45 A.M., E4 (housekeeper) was changing bed linens in room 104-1. E4 placed set of clean linens and blanket on top of an open drawer next to the bed of 104-2. E4 stated that she will use the set of clean linens for beds 1 and 2 in room 104. 2) On 10/24/2011 at 10:50 A.M., E4 (housekeeper) was changing linens in 111-2. E4 was using linens/blanket that was on top of bed in 111-1. 3) On 10/24/2011 at 11:00 A.M., E5 (housekeeper), carried multiple sets of linens and blanket by holding these lines next to her upper body and arms. E4 brought all these set of clean linens and placed on top of bed in room 306-1. E5 proceeded to change linens in 306-2 and was using the linens that was placed on top of bed 1. E5 stated that she will also use some of the linens in another room (302). Review of the facility's policy for linen handling showed to carry linens away from body, should not touch the body, carry linens into a resident room one set per bed at a time and that linens should not be stored in the resident's drawers for any reason.	F 441		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999		

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F9999	Continued From page 15 300.1210b)2) 300.1210d)5) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest 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: 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. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:	F9999		

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F9999	Continued From page 16 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. THESE REGULATIONS WERE NOT MET AS EVIDENCED BY: Based on observations, interview and record review the facility failed to address a resident's poor positioning and failed to identify a rash resulting from the resident's poor position. The facility failed to assess, provide interventions, and care plan to prevent limitations in range of motion to the neck. These failures resulted in 1 resident (R15) developing a neck rash with fungus and severe range of motion limitation of the neck. The sample size is 24. The findings include: R15 is an 81 year old, severely cognitively impaired resident who was re-admitted to the facility on 3/15/10 with multiple diagnoses, including Parkinson's Disease, according to the most recent Minimum Data Assessment (MDS) dated 9/14/11. R15 is totally dependent on staff	F9999		

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F9999	Continued From page 17	F9999		

for bed mobility, transfers, locomotion, dressing, eating and personal hygiene, according to the 9/14/11 MDS.

R15 was observed in her wheelchair with her head down and her chin touching the right side of her upper chest on 10/24/11 at 2:10 PM; 10/25/11 at 8:45 AM, 9:10 AM, 11:00 AM, 12:55 PM and 4:05 PM; and 10/26/11 at 8:45 AM, 10:05 AM, 10:20 AM, 10:41 AM and 10:55 AM.

On 10/26/11 at 10:55 AM E6 (Restorative Aide) said that R15 usually keeps her head down and her eyes closed. E6 lifted up R15's head slightly and held it. A deep red rash was noted in the skin folds of R15's neck. E3 (Restorative and Wound Nurse) was present at this time. E3 said that she was not aware that R15 had a rash on her neck.

On 10/26/11 at 11:10 AM Z1 (Doctor) examined R15's neck. Z1 said that R15 had a rash with fungus. Z1 said that he ordered anti-fungal cream.

On 12/26/11 at 12:36 PM E7 (CNA) said that she noticed that R15 had a rash on her neck in the morning but did not tell the nurse because she thought the nurse new about it.

On 12/26/11 at 11:20 AM E8 (Nurse) said that she was not aware that R15 had a rash on her neck.

R15 is an 81 year old, severely cognitively impaired resident who was re-admitted to the facility on 3/15/10 with multiple diagnoses, including Parkinson's Disease, according to the

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F9999	Continued From page 18 most recent Minimum Data Assessment (MDS) dated 9/14/11. R15 is totally dependent on staff for bed mobility, transfers, locomotion, dressing, eating and personal hygiene, according to the 9/14/11 MDS. R15 has bilateral functional limitations in range of motion of the upper extremity (shoulder, elbow, wrist, hand), and lower extremity (hip, knee, ankle, foot) according to the 9/14/11 MDS. The facility's Restorative Functional Assessment dated 9/14/11 does not assess R15's limited range of motion of her neck. Physical Therapy notes dated 1/5 - 1/12/11 document that R15 needs reminders to keep her head up and sit upright. R15's therapy discharge recommendations for restorative care dated 2/3/11 state "Encourage pts head position to be up." R15's Care Assessment Areas dated 3/18/11 does not assess R15's behavior of holding her head down. R15's care plan does not identify R15's behavior of holding her head down, and no interventions were planned. R15 was observed in her wheelchair with her head down and her chin touching the right side of her upper chest on 10/24/11 at 2:10 PM; 10/25/11 at 8:45 AM, 9:10 AM, 11:00 AM, 12:55 PM and 4:05 PM; and 10/26/11 at 8:45 AM, 10:05 AM, 10:20 AM, 10:41 AM, 10:55 AM and 2:25 PM. On 10/26/11 E3 (Restorative Nurse) said that there was no prior assessment of R15's range of motion to her neck. E3 said that the restorative functional assessment does not include a section for evaluating range of motion to the neck. On 10/27/11 at 12:10 PM E3 said that R15 did not have a care plan addressing R15's behavior of holding her head down and no interventions were planned.	F9999		

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F9999	Continued From page 19 On 10/26/11 at 1:50 PM E6 (Restorative Aide) said that R15 has been holding her head down more in the past 3 - 5 months. E6 said that R15 could previously holding her head up on her own, but now she cannot hold it on her own. E6 said "sometimes I turn her head" because she won't do it on her own. On 10/17/11 at 8:55 AM Z2 (Physical Therapist Assistant) said that when R15 was admitted in March of 2010 she din not have any neck issues according to the therapy notes. Z2 said that R15 was picked up by therapy again in January 2011 after she had a fall. Z2 said that at that time they noticed that R15 was starting to put her head down and needed cues to hold her head up and stand upright. Z2 said that no range of motion measurements were taken of R15's neck because range of motion wasn't a problem. Z2 pointed out that when R15 was discharged from therapy on 2/3/11 it was recommended that staff encourage R15 to hold her head up. On 10/27/11 Z3 (Physical Therapist) completed an assessment on R15. Z3 said that R15 cannot hold her head up on her own. Z3 said that R15 has severe limits to range of motion upon left rotation of the head. Additionally, Z3 said that R15 has functional limits to range of motion to all areas of her neck. Z3 said that R15 requires proper positioning/body alignment to reduce further reductions in range of motion. (B)	F9999		