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F 431	Continued From page 14 In an interview with E3, a nurse on the first floor, stated that she would dispose of the expired medications. In an interview with E4,a nurse on the second floor, stated that the Lantus insulin should be discarded.	F 431		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b) 300.1210d)3) 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. (Section 3-202.2a of the Act)	F9999		

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F9999	Continued From page 15 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 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements were not met as evidenced by: Based on record review, staff/physician interview, the facility failed to ensure 1 resident with sudden onset of abdominal pain was monitored and reassessed in a timely manner. This is for 1 of 2 closed records in a sample of 15. (R15)	F9999		

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This failure resulted in R15 being sent to hospital and admitted with diagnosis of sepsis and bowel obstruction. R15 subsequently expired.

Findings include:

A. R15's closed record revealed R15 is a 85 y/o female with history of Parkinson's, Diabetes Mellitus. R15's current Minimum Data Set assessed R15 as alert and able to make needs known, and requires assistance with all activities of daily living.

R15's computerized nurses notes entered by E11 (RN) 10/26/11 at 21:30 denotes the following: "pt c/o stomach pain, assessment done. Bowel sounds present in all four quadrants, v/s 123/55, 123, 96.4, 22. R15 described her pain as abdominal spasm and that it comes and go. MD notified and received new order to give Omeprazole 1 cap and Tylenol 650 mg tab tonight. New order carried out. R15 noted more comfortable 1 hour after medications were given. Endorsed to next shift for follow up."

There is no documentation of any pain reassessment entered by nursing until 10/27/11 for R15 until 0:700 on 10/27/11 by E7 (LPN), 9 1/2 hours after R15 started complaining of abdominal pain.

Documentation on 10/27/11 includes "R15 received in bed with c/o continued abd. pain. Pain is generalized in all quadrants. Abdomen distended with hypoactive bowel sound. Pt pale and diaphoretic. Noted to be extremely weak, barely able to lift arms, help turn or lift legs.

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Weakness is symmetrical. Blood sugar 236, b/p 134/64, p 135, sat 93 % on room air. MD notified of change in status and family notified. Pt transferred to hospital per ambulance at 7:45 AM. Pt was admitted with diagnosis of bowel obstruction.

E11 stated in phone interview on 11/8/11 she was informed by R15's CNA that R15 was complaining of a pain to abdomen upon transfer after evening shower. E11 stated upon assessment R15 complained of pain all over abdomen on and off, something like a cramp. E11 stated she checked vitals, checked for bowel sounds, notified MD, followed physician's orders and endorsed R15's complaint of abdominal pain to oncoming shift 11-7 nurse E8 (RN). E11 stated she also documented on 24 hour report of R15's complaint of abdominal pain and notification of physician.

E12 (CNA) was assigned to R15 on 10/27/11on the 11-7 shift. E12 stated in phone interview on 11/8/11 at 2:00 PM, "noticed R15 was different than she usually was, she wasn't communicating as usual. I saw R15 at least 3 times for incontinence care, didn't notice her with pain but she was sweating. I told E8 (RN). I think E8 went into check her. E12 stated he was unaware if R15 had a fever or any change in vitals. E12 stated he was not informed by E8 to obtain vitals on R15 on that night. E12 documented on 10/27/11 at 01:22 AM, "overall needs more help that usual."

E7 (LPN) stated on 11/3/11 at around 6:00 AM on 10/27/11, she found R15 diaphoretic, not speaking and lethargic in bed lying on her back. I

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did a blood sugar check on her it was elevated, called MD and got order to send her to emergency room. E7 stated she was not informed by E8 of any change in R15's condition during the night. E7 stated after E8 became aware of R15's decline, E8 told E7 R15 had a normal oxygen saturation and took her medications at 5:00 AM.

E8 (RN) stated in phone interview on 11/8/11, she did get report from
pm shift regarding R15's abdominal pain/distention on 10/26/11. E8 stated she checked on R15 3-4 times during the night and noted abdomen slightly distended but R15 said she was okay. E8 stated she gave R15 medications at 5:00 AM took them with no problems. E8 stated she couldn't remember if she did vitals they might be on computer notes. There was no documentation of any vitals or assessment of R15 entered by E8 on 10/27/11. A late entry was completed by E8 on 11/3/11, 7 days after R15 was discharged to hospital. Documentation includes:

- 12:30 AM-turned and repositioned. patient denies pain or discomfort, bowel sounds normoactive x 4 quadrants, abdomen slightly distended, soft non-tender.
-4:45 AM- checked pt. asked if she has discomfort and she claimed I'm okay
-5:00 AM-due meds given Omeprazole 20 mg p.o. tolerated well

R15's computerized discharge form identified R15's pain as moderate and score of 7 at time of transfer.

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F9999	Continued From page 19 Hospital record denotes R15 was admitted to ER with complaints of abdominal pain and nausea times 1 day. Z1 (physician) stated in phone interview on 11/8/11 he was notified of R15's initial complaints of abdominal pain on 10/26/11 and gave order to monitor R15's pain, Omeprazole and Tylenol. Z1 stated he was again notified of R15's worsening condition on 10/27/11 and gave orders to send R15 to hospital. Z1 stated R15 was initially thought to be septic with a urinary tract infection, was started on antibiotics in the Emergency Room with an elevated white count of 24, 000. Z1 stated R15's condition declined and was admitted to Intensive Care Unit. Further tests revealed a bowel obstruction due to a looped bowel. R15's condition was guarded, had surgery, but expired due to hypoxic respiratory arrest. Z1 stated if R15's worsening condition of 10/26/11 was noted earlier or monitored it could have been a better prognosis for R15. (B) . 300.1210b)5 300.1210c) 300.1210d)6) 300.3240a)	F9999		

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F9999	Continued From page 20 Section 300.1210 General Requirements for Nursing and Personal Care Section 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: 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 see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or	F9999		

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F9999	Continued From page 21 agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements were not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure that 2 out of 4 residents (R11 and R6) reviewed for falls, in a total sample of 15, were transferred appropriately and safely with the use of a transferring device. This failure resulted in a fall incident for R11 on 9/9/11. R11 sustained a fractured right ankle that required hospitalization. Findings include: 1. R11 has multiple diagnoses to include Osteoporosis, Difficulty walking, Alzheimer's disease, Dementia and Anxiety disorder. On 11/2/11 at 12:08 PM, R11 was inside the first floor small dining room, waiting for lunch to be served. R11 was alert, verbally responsive and was able to respond appropriately to questions. R11 denied any pain or discomfort during this observation. R11's quarterly MDS (Minimum Data Set) dated June 22, 2011 indicated that R11 has no problem with temporal orientation and recall. The MDS indicated the following information under Section G. Functional Status: - Transfer (how resident moves between surfaces including to or from bed, chair,	F9999		

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wheelchair, standing position (excludes to/from bath/toilet), scored - 3-2 (extensive assistance x one person physical assist),
- Toilet use (how resident uses the toilet room, commode, bedpan or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; adjusts clothes), scored 3 - 2 (extensive assistance x one person physical assist),
- walk in room (how resident walks between locations in his/her room), scored - 2 - 2 (limited assistance x one person physical assist).

R11's records indicated history of a fall on 6/24/11, when the resident did a self transfer from bed to the wheelchair without calling for help. Further review of R11's records reflects an investigation report dated 9/9/11 indicating, "Incident occurred on 9-9-11 at 6:30 AM. resident was in the bathroom in her wheelchair and was going to transfer from wheelchair to toilet seat. CNA was with her. When resident stood up and took a step, her knees buckle down and she fell on her knees (possibly twisting her ankle at this point). CNA was noted standing behind the wheelchair by Nurse who came in to give medications." "It was noted during the investigation that CNA had inappropriate transfer for the resident. She should have used a gait belt and should have situated herself next (on the side) to the resident and not standing behind the wheelchair without using a gait belt during the transfer."
The same investigation report reflects that R11 complained of pain on the right foot, after the fall incident. R11's physician ordered an x-ray of the right foot and ankle, which revealed a fracture to the right ankle. R11 was sent to the hospital for

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evaluation and treatment on 9/10/11 and came back to the facility on 9/12/11 with a short cast (from below knee to toes) on the right lower leg.

During a meeting with the facility on 11/3/11 at 10:00 AM, E2 (Director of Nursing) stated that due to R11's history of fall on 6/24/11, the resident is considered at risk for fall. E2 indicated that it is best practice for the staff to use a gait belt to assist residents with ambulation and transfers, for those requiring limited and extensive assistance. Per E2, the CNA (E6) should have used a gait/transfer belt to transfer R11 on 9/9/11.

On 11/3/11 at 11:45 AM, E6 (CNA/ Certified Nursing Assistant) stated that on 9/9/11 at around 6:30 AM, R11 was rushing to use the toilet, so she (E6) attempted to assist R11 during ambulation/transfer from the wheelchair to the toilet without the use of the gait/transfer belt. E6 stated that she was holding R11's left arm and left back side while R11 was walking towards the toilet. Per E6 during this process, R11's knees buckled, but R11 was able to continue walking. According to E6, the second time R11's knees buckled was the time when the resident fell on the floor. Per E6, R11's legs were in a crossed position when she fell on the floor and that R11 was sitting on her crossed legs on the floor. E6 stated that R11 was assessed by the nurse after the fall, but did not indicate any pain or discomfort. R11 was lifted manually from the floor after the fall and was placed back on her wheelchair. According to E6, R11 complained of foot pain (does not remember which foot) on 9/9/11 after breakfast. During the same interview, E6 acknowledged that she received orientation prior to 9/9/11, to use a gait/transfer belt, every

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time a resident is transferred and/or assisted. E6 acknowledged that she should have used a gait/transfer belt on R11, during the transfer assistance on 9/9/11.

Review of E6's file shows evidence that she (E6) received training regarding the use of gait belt during transfers on 1/17/11 and 5/17/11. E6's gait/transfer belt check- off sheet dated 1/17/11 and 5/17/11 indicated that the gait/transfer belt is applied to a resident, "When manual assist is required for general supervision, possibly limited assistance or assisting residents who have not been screened for a lift." The same gait/transfer belt check-off sheet indicated that a gait/transfer belt will be used to: "Help a resident to get up/sit down, Help a resident up from the floor, Transfer between bed and wheelchair or wheelchair and toilet, Support when walking, Protect resident who are unstable when walking and Help a resident maneuver when using the bathroom."

2. R6's current Physician's Order Sheet (POS) dated November, 2011 documented R6 as having diagnoses that include Psychotic, Mild Parkinson's, Multiple Falls at Home, Weakness, and Dementia. R6's ordered medications included Lorazepam, Fentanyl Patch, Ambien 5mg, and Seroquel.

On 11/01/11 at or about 11:00am R6's bed and wheelchair had alarms attached to them. Her bed was in low position. R6 was sitting in a wheelchair. She was calm and not attempting to get out of the chair. R6 stated, " I can not walk without a walker. My legs and shoulders are always in pain. I need help to get out of the

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chair."

R6's Nursing Note dated September 05,2011 documented R6 was found on the floor in the bathroom doorway... the Certified Nursing Assistant (CNA) was helping her, and when R6 turned around, the CNA was gone as R6 attempted to sit in her wheelchair. R6 was assessed as having no physical injury at the time of the incident.

When R6 was asked about the incident on 11/01/11, she could not remember the details of the incident. During the facility investigation of the incident, it was documented that R6 stated that the CNA helped her off the toilet. R6 was washing her hands with her walker in front of her. When she turned to sit down she fell on the floor. The CNA stated she thought the resident was able to walk to the chair by her self. The Director of Nursing (DON) informed the "new " CNA that she can not leave residents who have mobility alarms in the bathroom by themselves, and R6 was a one person assist with all care.

The Team Review of R6's fall incident on 09/05/11 recommended that the following interventions be implemented: " Instruct CNA's to use gait belt minimum assist while ambulating with rolling walker."

The Facility Lift Program Skills Check-off Sheet/Transfer Belt documented that E5, CNA, completed these requirements on 04/08/11. The sheet documented," Gait/Transfer Belt: Applications: When manual assist is required for general supervision... Help a resident to get up/sit down, ... Transfers between bed and wheelchair,

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F9999	Continued From page 26 or wheelchair and toilet, support when walking, Protect resident who are unstable when walking, and Help a resident maneuver when using the bathroom." On 11/03/11 at 10:55am E2, the DON, was interviewed regarding R6's fall incident of 09/05/11. E2 stated, " E5 was a fairly new CNA. She should have looked in the Kardex to review R6's care needs. R6 was on fall precautions prior to the fall incident. E5 should not have left R6 alone, especially since R6 is a fall risk. (B)	F9999		