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F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a 300.3240a) 300.3240b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.3240 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) These requirements were not met as evidenced by:	F9999		

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Based on record review, observation and interview, the facility failed to identify and immediately report to the Administrator and the Department, and investigate allegations of sexual abuse, staff to resident abuse, resident to resident abuse and injuries of unknown origin for 12 of 26 residents (R7, R23, R15, R22, R14, R20, R3, R17, R1, R18, R8, R9) reviewed for abuse and injuries of unknown origin in a sample of 31. The facility also failed to develop and operationalize abuse policies and procedures for identifying, reporting and investigating abuse allegations and injuries of unknown origin.

The findings include:

1. Review of the Care Plan on 8/21/12 for R7 noted a documentation of "8/2/12 res. (resident) exhibits inappropriate sexual behavior toward female residents". The "Goal" documented "8/2/12 will have no inappropriate behaviors". E3, Registered Nurse (RN) and Care Plan nurse confirmed on 8/21/12 at 2:50 PM that she had written the entry. E3 stated R7 had both hands on R14's breasts in the dining room area. E3 stated she had not reported the incident because she had become busy and forgot.

E1, Administrator, stated on 8/21/12 at 3:08 PM that she was unaware of R7 putting his hands on R14's breasts. E1 stated she has seen R7 touching R31 on the leg before and made him move away. E1 stated there was no abuse investigation done for the incident with R7 and R14.

The Department was notified in writing on

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8/22/12. E1 documented "On 8/17/12 resident (R7) put hand on (R14's) breast on outside of shirt. Staff separated residents immediately. Staff did not report this to administrator however did fill out an incident/accident report and did chart incident. Social Service will meet with resident today and call for new psychiatric evaluation for inappropriate behavior. State surveyor is in the building at this time and is aware of incident".

Review of the nurses notes on 8/17/12 by E12, RN, documented "6:30 PM-Resident was noted to be sexually inappropriate behavior toward another resident while sitting in the living room with staff nearby. Resident was easily redirected. (Physician) et (and) informed et NNO (no new orders)".

In an interview with E1 on 8/22/12 at 9:30 AM, she stated the 8/2/12 and 8/17/12 incidents were the same incident. E1 stated E3 had written 8/2/12 on the care plan but it should have read 8/21/12. E1 called E3 into the room. E3 stated the incident report from E12 regarding the incident with R7 and R14 was under her door when she came in on the morning of 8/21/12. E3 stated the care plan should have read 8/21/12 and she had forgotten to put the 1 on 21. E3 then stated on 8/22/12 at 9:50 AM that she had a "note" not the incident report from E12 that said to read the nurses notes from 8/17/12. E3 stated she wasn't sure why E12 had waited to report the incident.

E12 stated in an interview on 8/22/12 at 9:20 AM that she filled out the incident report on the evening of 8/21/12. E12 confirmed she dated the

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incident report 8/18/12. E12 stated she didn't realize she had to fill out an incident report and didn't "know it was that big a deal".

E12 stated during the evening medication pass on 8/17/12 a family member came to her and said she had seen R7 "pat her (R14) on the breast and vagina". E12 stated she did not see the incident but did call the physician and chart it. E12 stated it was very busy that night and she didn't report it. E12 stated she was not aware of R7 touching R14 at any other time. E12 stated she felt R7 knew what he was doing and E12 had told R7 he shouldn't be touching R14 and he responded "OK".

The "Incident Report" dated 8/17/12 by E12 documented the type of incident as "Sexually Inappropriate Behavior". The description documented, "Resident was noted by staff member he patted a female resident breast and pat her vagina (with) his hand". The incident report identified the witness as E12. E12 documented the residents were separated and monitored frequently.

E7, Social Service Director, stated in an interview on 8/21/12 at 3:05 PM that she had been notified of the incident today, 8/21/12, "right before 2:00 PM" and had contacted the psychiatrist for this incident of inappropriate sexual behavior. E7 stated the psychiatrist had not seen R7 for this behavior.

The annual Minimum Data Set (MDS) dated 12/23/12 for R7 documented R7 scored a 14 out of 15 on the "Brief Interview for Mental Status (BIMS)" for cognitive pattern questions. There

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was no behavioral symptoms documented. R7 was assessed as independent for ambulation. Diagnoses included, in part, affective psychoses, Bipolar Disorder, schizophrenia, and cerebral vascular disease.

R14 was observed to wander about the facility during the survey. R14 would not answer questions appropriately. According to the MDS dated 3/28/12, R14 was assessed as independent with ambulation. R14 could not conduct the BIMS test for cognition on the MDS. According to the Physician Order sheet, R14 has diagnoses in part, of dementia, schizo-affective disorder, psychosis, and delusions.

2. On 7/2/12 the facility administrator, E1, notified the Department with a written report of E27, Certified Nurse Aide (CNA) "smacking" R23 on 6/25/12. The report documented E27 was suspended and an investigation initiated on 7/2/12.

E35, Activity Aide, documented in a written statement dated 7/2/12 that on 6/25/12, E34, Activity Aide, had told her he saw E27 "smack (R23) on the back of the leg. He (E34) looked really worried but told me it was not a hard smack; but nevertheless a smack. We did not report it to the charge nurse or tell anyone what happened. We chose to just report it to you".

E34, Activity Aide, documented in a written statement dated 7/2/12 "On June 25 th, (E35) and I were passing out the July activity calendar and I heard (R23) yelling Help!, as I walked by her room I saw (E27) smack (R23) in the back of her leg, while changing her. I didn't know if it was

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acceptable since it was not brutal, but she did hit her so I wanted to report it. (E35) and I are the only ones who know about this incident".

E1 confirmed on 8/25/12 at 9:45 AM in an interview that the incident was not immediately reported to her. E1 stated the incident occurred on 6/25/12 and she was notified on 7/2/12. E1 stated R23 was not harmed and E27 was terminated on 7/2/12.

3. On 5/30/12, E1 notified the Department of an allegation of abuse that occurred on 5/29/12. E1 stated in an interveiw on 9:45 AM that E26, CNA, called R15 a name on 5/29/12. E1 stated the allegation was reported to her on 5/30/12 and E26 was removed from the building and terminated. E1 stated there was no harm to R15.

E1 documented "On May 30, 2012 at 7:30 AM it was brought to my attention by the day nurse, E38, LPN, that she overheard two certified nurse assistants having a conversation about a different certified nursing assistant being unprofessional towards a resident". E1 also documented she interviewed E36, CNA, that overheard the conversation between R15 and E26 and he stated "I heard (E26) and (R15) in shower room and (E26) told resident, "You scratched me you b--ch"." E1 documented R15 was interviewed and stated "That little girl called me the devils name".

In a written statement dated 5/30/12, E36, CNA, documented on 5/29/12 he was taking a resident to the bathroom and E26 was giving R15 a shower. E36 documented that R15 scratched E26 and E26 called R15 a "B--ch".

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In a written statement dated 5/30/12 by E37, LPN, she documented R15 told her "that there was someone who was mean to her". R15 told E37, "She called me devils names".

4. The Incident Report Log dated 7/4/12 documented R22 was "slapped on the head by another resident". The Incident Log also documented R14 "slapped another resident".

An "Incident Report" dated 7/5/12 by E39, former LPN, documented R14 slapped R22 on the head. The incident documented E1 was notified of the incident. E1 stated in an interview on 8/23/12 at 11:45 AM that she was not aware of the incident with R22 and R14 and there was no incident or abuse report investigation.

The nurses notes for R14 by E39 dated 7/5/12 at 7:00 AM documented "This resident ambulating the east hallway. A resident in a w/c (wheelchair) on east hallway yelled at this resident. This resident then slapped the other residents head. (No) injury". The nurses notes dated 7/5/12 at 10:00 AM for R22 documented she was slapped by another resident.

The nurses notes by E2, former Director of Nursing, dated 7/5/12 at 8:00 PM documented "(R14) slapped another resident in the back of the head and called her a "B--ch". Frequent reminders and attempts made to keep resident on her side of facility".

R14 was observed to wander about the facility during the survey. R14 would not answer questions appropriately. According to the MDS

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dated 3/28/12, R14 was assessed as independent with ambulation. R14 could not conduct the BIMS test for cognition on the MDS. According to the Physician Order sheet, R14 has diagnoses in part, of dementia, schizo-affective disorder, psychosis, and delusions.

5. The Incident Log dated 7/19/12 documented R3 "hit resident" and "pulled another res. (resident) hair". The Incident Log dated 7/19/12 documented R20 "hair pulled by another res." The nurses notes for R3 and R20 for the 7/19/12 incident have no documentation regarding the incident.

The "Incident Report" for R3 dated 7/19/12 completed by E11, LPN, documented "Res. (resident) pulled another res. hair". An "Incident Report" dated 7/19/12 for R20 documented "Hair was pulled by another pt. (patient)". Neither of the reports for R20 and R3 documents that E1 was notified of the incident. E1 stated in an interveiw on 8/23/12 at 11:45 AM that she was not aware of the incident and there was no incident or abuse investigation done.

The Medication Administration Record for R3 documented diagnoses, in part, as neurogenerative brain disease, Bi Polar disorder, and Psychosis. There is no documentation in the nurses notes for R3 regarding the incident with R20. The Care Plan for R3 dated 6/29/12 does not identify problems with physical aggression to other residents. On 8/14/12 "Resident hitting other residents" was added to R3's Care Plan after she was sent to the emergency room for hitting another resident.

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6. The Incident Log dated 8/14/12 documented R17 was "hit by res. (resident)". The Incident Log dated 8/14/12 documented for R3 "Aggravated by another res. in her way". E1 stated in an interview on 8/23/12 at 11:45 AM that the incident did not occur and there was no incident or abuse investigation done. E1 stated E7, Social Service Director, witnessed the incident and nothing happened. E1 was not sure why R3 was sent to the hospital due to the incident.

The "Incident Report" for R3, documented by E8, Registered Nurse (RN), for 8/14/12 at 8:00 AM documented that R3 and R17 were in the lobby and R3 asked R17 what she was staring at. The Incident report documented R3 hit R17 several times in her right arm. The report documented E2, Director of Nursing, was notified of the incident. A sticky note dated 8/23/12 was on the report for R17 and stated "(E7 and R17) stated this did not happen. (E7) witnessed (R3) touched (R17's) arm (no) slap". The sticky note was not signed.

E7 stated in an interview on 9/11/12 at 11:15 AM that R3 did not hit R17. E7 stated R17 was sitting in a wheelchair and R3 asked R17 what she was staring at. E7 stated R3 touched R17's arm and didn't punch her.

There was no documentation in the nurses notes for R3 regarding an incident on 8/14/12 at 8:00 AM. The nurses notes dated 8/14/12 at 10:00 AM by E8 documented for R3 "Resident was propelling self around facility when another resident was pacing and this resident punched her in the resident's head a few times. Another nurse witnessed this. At 10:00 AM the nurse that

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witnessed this came and got me and stated call MD (Medical Doctor) and send out for behaviors". The nurses note documented the physician was called "about resident hitting other resident. Also yelling @ (at) staff. MD stated to send to ER (emergency room) @ (local hospital) for behaviors". R3 was admitted to the hospital and readmitted on 8/24/12.

E20 stated in an interveiw on 9/11/12 at 11:05 AM that R17 was rolling past R3 around lunch time in the front lobby area in front of the dining room. E20 stated R3 made a comment to R17 and then R3 hit R17 in the face with her fist. E20 stated R17 was taken aback but didn't hit back. E20 stated she reported the incident to the nurse on 200 hall. E20 stated E7 observed the incident.

E8, RN, stated on 8/29/12 that she did not see R3 hit R20 on 8/14/12 at 10:00 AM but it was reported to her by another nurse, E20, LPN. E8 confirmed the physician was called and R3 was sent out to the emergency room due to aggression. The nurses notes on 8/14/12 at 10:05 AM documented R3 was sent to the emergency room for "behaviors".

The "Resident Transfer Form" from the facility to the hospital for R3 dated 8/14/12 documented the "Reason for Transfer" as "Physically abusive to another resident". The documentation under "Additional Pertinent Information" stated "Resident was there a couple of weeks ago. Please do something to help her. Med (Medication) change??".

R17 stated in an interview on 8/20/12 everything was "Fine" when asked if she was having any

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problems. R17 stated "no" when asked if she was afraid of any residents or staff and then wheeled away.

Z6, Power of Attorney for R17, stated in an interview on 8/27/12 at 2:10 PM that R17 told her that another resident had slapped her on the arm. Z6 stated R17 was very nervous at the facility and she had said she was afraid. Z6 stated R17 told about an incident where a resident had attacked a staff and hit her in the face. Z6 stated R17 was crying. Z6 stated R17 was fearful when doing physical therapy in the halls with residents around her. Z6 stated they moved R17 and R16 both to another facility.

The hospital history and physical dated 8/17/12 documented R3 was "reportedly aggressive at her nursing home residence". Her diagnoses include, in part, "Bipolar disorder by history in a patient with residual history of alcohol and substance abuse" and "Multiple medical problems". R3 was discharged on 8/24/12 back to the facility.

7. On 8/28/12 at 9:50 AM, R18 was seen sitting in his wheelchair in the front lobby. R18 pointed at his left hand with his right and stated "it hurts!" R18 then pulled on the bottom of the sleeve of his sweatshirt, trying to pull the sleeve up. R18's left hand was swollen at least twice the size of his right hand, and was dark blue and black. The bruising extended up his forearm to his elbow.

On 8/29/12 at 10:50 AM, several of R18's family members were visiting - including R18's Power of Attorney (POA), Z5. Z5 said that she first noticed

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R18's swollen, bruised hand "day before yesterday - it was turning black on Saturday". Z5 said that R18 had deep ridges in his hand on 8/28/12. Z5 said "I wonder if he's getting all bruised up in the siderails".

On 8/28/12 and 8/29/12, the Facility Incident/Accident log was reviewed. There is no documentation regarding R18's swollen, bruised hand. On 8/28/12 at 2:00 PM, E1 was interviewed concerning R18's swollen, bruised hand. E1 was unaware of R18's swollen, bruised hand. On 8/29/12, at 9:25 AM, the Facility still had not investigated how R18's hand had become swollen and bruised. R18 was once again complaining of pain on 8/29/12 at 9:15 AM.

8. R23 was observed pushing her wheelchair throughout the Facility during the day of 8/29/12. At 1:10 PM, R23 wheeled herself into the conference room. The left arm of the short sleeved shirt which R23 was wearing had been pushed up. A thumb-sized, blue/black bruise was visible on R23's upper left arm - halfway between her shoulder and elbow. R23 was interviewed and was unable to answer questions appropriately.

At 2:30 PM on 8/29/12, R23's bruised left upper arm was brought to the attention of E8, Registered Nurse (RN). E8 said that she was unaware of any bruises on R23. E8 took R23 into her room and examined her upper body. E8 said that there is no other bruising on R23's upper body. E8 confirmed the 1 - 1 1/2 inch round bruise on R23's left upper arm. E8 stated "It looks like it's been there awhile".

The Facility Incident/Accident log was reviewed

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on 8/29/12. R23 is not listed on the log. E1, Administrator, confirmed on 8/29/12 at 3:30 PM that none of the staff reported the bruising to R23's upper left arm. E1 confirmed that no investigation into the thumb-shaped bruise was conducted by the Facility. There is no documentation in R23's clinical record regarding any bruising.

R23 was originally admitted to the Facility on 8/15/08. R23's diagnoses include Alzheimer's, Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. R23's physician orders documents that she takes 75 milligrams of Plavix daily.

R23's plan of care documents a "Problem" of "Potential for skin breakdown related to low mobility and incontinence". The "Goal" documents "resident will maintain clean and intact skin". The "Interventions" include: "Inspect skin integrity with daily care".

9. On 9/5/12, at 11:35 AM, R8 was sitting in the lobby. R8 had a dressing wrapped around his right hand. A 1 inch portion of a skin tear was visible on the top of his hand above the dressing. R8 stated "Boy it hurts! It's all tore up. One of the nurses grabbed my arm. I don't know who did it".

At 11:40 AM, E11, LPN, took R8 to his room to provide a treatment to his hand. E11 removed the dressing on R8's right hand. R8 cried out "that hurts!" A 2 inch "L" shaped skin tear was noted on the top of R8's right hand. A crescent moon shaped skin tear, 1 1/2 inch by 1/2 inch, was located on the outside of R8's right hand.

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E11 applied Triple Antibiotic Ointment (TAO) to the skin tears on R8's right hand and redressed his hand.

R8's Facility "Skin Tear/Bruise Accident/Incident Checklist" documents that on 9/2/12, at 9:00 AM, "Resident became combative and agitated while being provided care. Resident received a 3 centimeter (cm) long skin tear to his right hand and above the thumb area". The "Cause or Contributing Factors" documents "Hitting out at nursing staff". The "Intervention" documents "Treatment to left hand". The investigation does not state how the skin tears occurred. On 9/5/12 at 11:20 AM, E1, Administrator, confirmed that the Facility did not thoroughly investigate how R8's skin tears occurred. E1 said that she did not know if he hit his hand on something or if it was caused by staff holding his hands. E1 stated that they did not investigate the incident for potential staff to resident abuse.

10. The hospital "History and Physical", dated 9/3/12, documents that R9 was admitted to the hospital on 9/3/12 for "Changes in mental status". During a telephone conversation with Z7, hospital Social Services, on 9/4/12 at 1:40 PM, it was stated that the hospital was very concerned about a large bruise noted upon admission that extends across R9's entire lower back and buttocks.

On 9/4/12 at 2:35 PM, R8's bruising was observed in her Intensive Care Unit (ICU) room at the hospital. The bruising extended from the outside of one hip, across her entire lower back, to the other hip - in a boomerang shape. The largest portion of the bruise measured 8 inches and was located right above R9's tailbone. This

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area was deep purple in color. The width of the bruise became smaller as it extended out to each of R9's hips. The width measured 6 inches above each buttock and 4 inches on the side of each of R9's hips. The bruising on R9's right hip was deep purple. The bruising on R9's left hip was yellow and purple. Upon questioning, R9 was unable to verbalize how the bruise occurred.

The hospital Social Services Notes, dated 9/4/12 at 10:34 AM, document "Patient stated, "I'm tired of being beat on". Patient is a resident of (Facility). I met with patient who has some dementia. Patient did confirm that she is being hit. Patient's POA has some concerns about patient possibly being abused as patient has bruises on her backside and she wishes the abuse to be reported. Patient does indeed have large bruising on her lower back and buttocks".

E25, Certified Nurse Aide, stated in an interview on 9/5/12 at 12:30 PM that she had toileted R9 prior to her going to the hospital on 9/3/12. E25 stated she observed a "nice size", "dark colored" bruise on R9's left buttocks. E25 stated she did not report the bruise to E8, Registered Nurse. E8 stated in an interview on 9/5/12 at 12:46 PM that E25 had not reported a bruise on R9's buttocks to her.

The "Incident Log" dated 8/25/12 documented R9 had fallen and bumped her hand. A bruise was documented but not the location. The Nurses notes dated 8/25/12 at 6:00 AM documented R9 came to the nurses station and stated "nobody cares that she fell hard". R9 also stated "she has fallen in bathroom that someone was with her". No bruises were noted. The nurses notes on

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8/25/12 at 11:00 AM documented bruising to right arm and hand. A "Skin Tear/Bruise A/I Checklist" with the date of 8/25/12 at 6:00 AM documented skin observations and checked "red" and "purple" but did not describe the skin or the location.

The "Incident Log" documented R9 had fallen on 8/26/12 at 5:10 AM and no injuries were noted. The "Fall Investigation Report" dated 8/26/12 at 5:10 AM documented "no injuries". The nurses notes dated 8/26/12 documented R9's "knees buckled down to floor on buttocks per CNA. Res was not injured". According to the nurses notes dated 8/28/12 an Xray was done due to complaints of hip pain with "mild osteoarthritis" documented as the results. The nurses notes from 8/26/12 through 8/30/12 does not describe any bruising to R9.

E1, Administrator, stated in an interveiw on 9/4/12 at 1:40 PM that Z7 had called from the hospital and said R9 had told them "someone abused her". E1 stated R9 "says that all the time". All abuse investigations had been previously reviewed and there was no abuse investigations for R9.

E1 stated in an interveiw on 9/5/12 at 12:20 PM that a full body assessment of R9 was done on 8/28/12 and they saw no bruising at that time. E1 stated she even had E3 and E8 look and there was nothing there. E1 confirmed and provided the 8/28/12 shower sheet.

The "Skin Monitoring: Comprehensive CNA Shower Review" dated 8/28/12 documented a round bruise on R9's left upper hip and coccyx area. There are no measurements documented.

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The nurses notes dated 8/31/12 documented "4 AM CNA reported bruise to lower back/buttocks, area purple et (and) yellowed. Res has had two recent falls". There was no incident or abuse investigation report done on 8/31/12.

The Facility was made aware of R9's allegation of abuse reported to the hospital staff on 9/4/12 at 1:40 PM. As of 4:00 PM on 9/5/12, the Facility has not investigated the allegation of abuse or the bruising of unknown origin.

11. Facility staff were interviewed and did not always report an allegation of abuse would be reported to the Administrator. E40, CNA, stated in an interview on 8/23/12 at 2:55 PM that she would report any abuse to the nurse and then to the supervisor. E40 stated "I don't know if (I) can report to the Administrator". E40 stated the CNA's cannot pick up the phone and call the Administrator themselves.

E9, CNA, stated in an interveiw on 8/23/12 at 3:00 PM that she would report any abuse to the charge nurse who would then report it to the Administrator. E9 stated she would follow the chain of command.

E22, CNA, stated in an interview on 8/23/12 at 4:00 PM that she would report any abuse to the charge nurse who is in charge.

12. The facility Abuse policy and procedure titled "Protection of Residents: Reducing the Threat of Abuse and Neglect, Chapter 2" documented "All personnel will promptly report any incident or suspected incident of resident abuse and/or

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F9999	Continued From page 152 neglect, including injuries of unknown origin". The policy and procedure also states "All alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown origin (eg., bruising and skin tears) will be promptly reported to the administrator and/or director of nursing". The policy and procedure also documented "The person(s) observing an incident of resident abuse or suspecting resident abuse will immediately report such incidents to their immediate supervisor and/or the charge nurse". The policy and procedure documented "If it is determined that alleged abuse and/or neglect has occurred, the administrator, director of nursing, or his/her designee will promptly notify officials in accordance with state laws and corporate practices". (A) 300.610a) 300.1210b) 300.1210d)5) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at	F9999		

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F9999	Continued From page 153 least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not 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	F9999		

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F9999	Continued From page 154 services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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 observation, interview and record review, the facility failed to provide the recommended low air loss mattress; failed to provide ordered treatments; failed to revise the	F9999		

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treatment plan to ensure that the treatment that is implemented is being documented in the clinical record; failed to notify the physician or the pharmacy of the unavailability of the ordered treatments; failed to implement proper turning and repositioning; failed to update care plans, failed to prevent pressure sores, failed to follow facility policies and procedures for pressure sores, and failed to prevent decline of pressure sores for 3 of 4 residents (R1, R 2, R5) reviewed for pressure sores in the sample of 31. This failure resulted in R2 developing a stage IV Pressure sore which required hospitalization for sepsis, debridement of the wound and a condition suggestive of osteomyelitis. R5 had a facility acquired pressure ulcer that declined to a stage IV.

Findings include:

1. R2 was admitted to the facility on 4/29/10. The hospital history and physical dated 7/5/12, documents that R2 has diagnoses, in part, of Alzheimer's with dementia, depression, diabetes mellitus type two, stress incontinence, and history of uterine cancer with metastasis to the ovaries with hysterectomy and bilateral salpingo-oophorectomy in 2010.

The Nurse's Notes and Weekly Wound Report dated 4/10/12 first documented R2 had a facility acquired open area on her coccyx measuring 7 cm x 2 cm x 0.3 cm. The nurses note documented on 4/10/12 "This writer noticed an open area during skin check. Noted 7 cm (centimeter) x 2 cm x 0.3 cm open area (every) 3 days (and) PRN (as needed) until healed". The physician was notified.

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The Physician Order Sheet (POS) dated 4/10/12 documented the following order: "cleanse coccyx with NS (normal saline), pat dry, apply DuoDerm to 7 cm x 2 cm x 0.3 cm open area (every) 3 days et (and) PRN (as needed) until healed". The Physician also ordered "DuoDerm to the L (left) buttock (change) every 3 days. Cleanse 1st (with) NS (Normal Saline)".

On 4/25/12 the order was changed to Santyl ointment to coccyx daily and as needed. According to the Treatment Record dated 4/25/12 the pressure ulcer on the coccyx was 3.5 x 4.5 x 0.5.

On 5/1/12 the "Physician's Orders Medications and Treatments" ordered "Outside Wound Consultant" to consult and tx (treat) wound(s) as indicated". The outside wound consultant Initial Consult was not done until 5/9/12. The initial consult by Z2, Nurse Practitioner wound consultant, documented an "unstageable pressure ulcer of the coccyx" at 3.6 cm long x 1.5 cm wide x necrosis. Z2 recommended a low air loss mattress, offload pressure, up only for meals, turn side to side every 1 to 2 hours when in bed, and toilet every 1-2 hours for fecal and urinary incontinence. R2's weight was documented as 187 pounds. Z2 recommended to continue with current treatment plan.

On 5/9/12, Z2 wrote, "I do recommend a low air loss mattress... ". Z2 documented the recommendation on the POS, and included it as part of the Care Plan for R2's Weekly Wound Report. Z2's reports from 5/9/12 through 6/26/12 documented "Still awaiting on low air loss

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mattress at this time". The Nurses Note dated 6/8/12, documents, "(E1, Administrator) notified of the need for low air loss mattress. "

Weekly Consultant Reports from 5/9/12 thru 6/12/12 documented, " Improvement/ Wound response as anticipated. " The 6/19/12 reported , "No changes for 1 week." R2's weight was documented as 187 pounds from 5/9/12 through 6/26/12 on the wound report.

On 6/26/12, Z2 documented, "Wound status: Declined ". Z2 documented a corresponding change in the treatment to "start NS (normal saline) cleanse, apply Santyl and Bactroban, approx (approximately) 50/50%, cover with dry dressing, change daily and PRN". Z2 documented "Still awaiting on low air loss mattress at this time". The wound measurements were 2.5 cm x 0.9 cm with depth as "necrosis"for the "unstageable pressure ulcer of the coccyx". R2's weight was documented as 187 pounds.

The facility "Weekly Wound Report Pressure" dated 6/27/12 documented the wound measurements increased from 2.0 cm x 0.5 cm on 6/20/12, to 2.5 cm x 0.9 cm on 6/27/12. On 7/5/12 the "Weekly Wound Report Pressure" documented an increase in the coccyx pressure ulcer size to 2.6 cm x 0.9 cm.

On 7/3/12, Z2 documented , "Unstageable pressure ulcer measuring 2.6 cm long x 0.9 cm wide x necrosis". The facility "Weekly Wound Report Pressure" dated 7/5/12 documented the size of the coccyx pressure ulcer for R2 as 2.6 cm x 0.9 cm.

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The Nurses Note dated 7/5/12 document, "Transferred to (a local area hospital.) . . and admitted with diagnosis of Dehydration, acute renal failure, hypernatremia and urinary tract infection. The hospital history and physical, dated 7/5/12, document R2's laboratory findings as sodium 162 (132-146), Blood urea nitrogen as 54 mg/dl (milligram/decaliter (9-23), creatinine 1.10 mg/dl (0.5-1.1). A laboratory report dated 7/5/12 documented R2's Albumin as 4.3 G/dl (gram/decaliter) (3.2-4.8) which indicates normal visceral protein stores required for wound healing.

R2 was readmitted to the facility on 7/9/12, according to the Admission Nursing Assessment dated 7/9/12, which documents, "Stage IV to coccyx." There were no measurements of the pressure sore documented. The Hospital Discharge Order dated 7/9/12 written in the Physician Order Sheet (POS) documents "Aquacel AG, 4 x 4 dressing to coccyx and buttocks daily after cleansing with normal saline solution then apply DuoDerm. "

Z2's report dated 7/10/12 documents, " Unstageable pressure ulcer measurement 6.5 cm long x 9.0 cm wide x necrosis. Also on 7/10/12, Z2 wrote in the POS, "Discontinue current treatment, start cleanse with wound cleanser, apply santyl, Bactroban approximately 50/50, mix, then apply Calcium alginate to wound bed then apply Xenaderm to periwound, cover with abdominal dressing, change daily and as needed. The wound consultant documented R2's weight as 160 pounds which is a 27 pound weight loss from the 6/26/12 wound consultant report. This reflects a significant weight loss of 14% from the

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F9999	Continued From page 159 6/26/12 weight of 187 pounds to the 7/10/12 report of 160 pounds. On 7/17/12, Z2 reported an increase in size of the wound which now measured 11 cm long x 9.5 cm wide x necrosis with large amount of yellow drainage with mild foul odor. The "wound status: declined" was documented. Z2 continued to recommend low air loss mattress. On the outside consultant Report dated 7/17/12, Z2 wrote, "patient is still awaiting on her LAL (low air loss) mattress at this time". At this time Z2 changed the treatment to Silver Alginate daily. On 7/24/12, the Wound Management Report documents "Staff reports that they are currently out of Silver Alginate, so they are going to be using Santyl and Bactroban in the meantime until the Silver Alginate arrives". Z2 also documented "We are currently still awaiting a LAL (low air loss) mattress". Z2 documented R2's weight at 160 pounds with a low albumin level of 2.8. The "coccyx and bilateral buttocks" pressure ulcer was assessed by Z2 as measuring 11 cm x 9.6 cm with "necrosis" for depth. Z2 described a large amount of yellow exudate with a mild foul odor that "seems to be improving". Z2 requested "Weight loss: Dietary consult at this time recommended secondary to weight loss and non-healing wound". On 7/27/12, Z8, Registered Dietitian, documented on the "Nutrition Assessment" to continue a pureed diet with supercereal at breakfast, house supplement three times per day, Arginaid 1 packet three times per day, weekly weights and to encourage intake. Z8 documented R2's weight on 5/12-188.2 pounds, 6/12-177 pounds, and	F9999		

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7/12-160 pounds. The 7/27/12 assessment by Z8 documented R2 was receiving a "Pureed" diet and "(No) supplements". The "Nutrition Assessment" dated 8/15/12 by Z8 documented the diet order as "Pureed" and on "8/14/12 sc @ bkst (Super cereal at breakfast), HS TID (House supplement three times a day), Arginaid 1 pkt (packet) TID (three times per day)". The "Physician's Orders Medications and Treatments" documented R2's diet as "Pureed Regular with Thin Regular Liquids". The July and August order sheets do not document any orders of the recommended nutritional supplements for R2. The May through August "Treatment Administration Record" and "Medication Administration Record (MAR)" do not reflect the house supplements. The Arginaid was documented as given beginning on the August MAR on 8/14/12.

The "Record of V/S (Vital Signs) and Weights" documented R2's weight as follows: April-187 pounds, May-188.2 pounds, June -167 pounds, July-159.2 and August-164 pounds. The physician "Progress Note" dated 6/1/12, 6/8/12, and 7/19/12 does not document R2's weight loss.

E11, LPN, stated in an interveiw on 8/22/12 at 11:00 AM that R2 "eats good". E11 stated R2 just needs time to eat and she will eat. E11 was observed feeding R2 on 8/16/12 for the noon meal in her room. E11 stated R2 has to be fed and will drink with a straw.

On 7/31/12, the Wound Management Report documents a decline in R2's wound status. Z2 documented the wound size had increased and measured 11 cm x 13 cm x necrosis with

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tunneling at 12:00 at 3 cm. The wound bed was covered with brown and black necrosis, bone is palpable, with copious amount of brown drainage of very foul odor and reddened periwound. Z2 documented on the Report "Upon exam today the wound has declined and there is a very foul odor upon taking off the dressing". Z2 also documented "patient is still awaiting on her LAL (low air loss) mattress at this time". Z2 documented that staff reported they are still unable to provide Silver Alginate and continued treating the area with Santyl and Bactroban and that R2 was still awaiting for the low air loss mattress. Z2 documented "At this time after discussing the patient's overall status and wound decline with patient's PCP (primary care physician) and (Z1), nurse practitioner, we have decided that it is appropriate to send the patient to the ER (Emergency Room) at this time to further evaluation due to risk of sepsis, and osteomyelitis of the wound".

The Nurses Note dated 7/31/12 documented that R2 was transferred to a local area hospital for wound debridement and possible sepsis.

The hospital "Medical Consultation Report" dated 8/4/12 documents that R2 was taken to the operating room for debridement on 8/1/12 and underwent excisional debridement of a 15 x 20 cm sacral decubitus with osteoectomy of infected-appearing bone. The report documents "Findings included sacral bone and coccyx that was quite soft, suggestive of osteomyelitis". The consultation report documents "Assessment: Infected sacral decubitus with osteomyelitis involving the sacrum and the coccyx, now with concurrent bacteroides septicemia", and

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"Staphylococcus, not aureus, bacteremia". R2's albumin level was documented as 2.6. This is identified as a "severe" deficiency of visceral protein store required for wound healing according to The American Dietetic Association "Nutrition in Long-Term Care Facilities".

The Hospital "Surgery Consultation" Report dated 8/1/12 documents R2 was sent to the emergency room from the nursing home with a sacral ulcer infection. The report documents "She has been treated for her wounds, with at least on July 17, 2012, with wound cleanser and silver alginate; however the wound continued to worsen as her overall condition declined". The report documented that at the time of admission R2's white blood count was 10,500 and she appeared to have a urinary tract infection. The "Assessment" documented a "Stage IV sacral pressure sore". The Surgery Consultation Report documents: "Plan: She has a very large wound on her sacrum that definitely needs benefit from debridement and good local wound care. Plan to proceed to surgery to debride this and hopefully today if okay with the primary care service. The recommendations for now are: 1) Local wound care. Continue dressing changes and debridement of this wound. We will then begin Dakin changes after. 2) Pressure relief. Recommend optimizing with a first step air overlay and regular reposition every two hours. 3) Nutrition. Optimize nutrition. Her current albumin is around 3, this could be improved slightly".

The "Operative Report" dated 8/1/12 documents "Excisional debridement of a 15 cm x 20 cm sacral decubitus with ostectomy in preparation for

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flap closure". The report documents all necrotic tissue was debrided "down until it was clear that the sacrum was identified as well as the coccyx. The bone was debrided down to good viable bleeding bone".

According to R2 's hospital Transfer Form dated 8/7/12, R2 returned to the facility on 8/7/12 with diagnoses significant for infected sacral decubitus, osteomyelitis and post wound debridement. The hospital Physician orders for treatment for the Stage IV Pressure sore were for Aquacel AG to ulcers on the coccyx and buttocks every morning, Versiva XC to ulcers on the coccyx and buttocks every morning and apply over the Aquacel AG and 1/4 strength Dakins solution to apply to the wound.

The Treatment Administration Record (TAR) for August 2012 documents that Dakin's solution, Aquacel AG, and Versiva XC were not administered to R2 as ordered. The TAR indicated the treatments were not done as documented by the encircled initials from 8/8 thru 8/15 for the Versiva XC and the Dakin's solution and for Aquacel Ag from 8/8 thru 8/12.

On 8/16/12 at 8:55 AM, R2 was observed lying in bed with dark, tea colored urine. There was no water pitcher in the room. R2 was observed lying in bed with one pillow under her back. R2 was not on her side or off loaded off of her back. At 10:10 AM, E19 told E14, CNA, to position R2 off her back and "Put her on her side". E14 replied she was on her side. E19 then told E14 to put R2 on her side. E19 rolled her eyes and went back to the nurses station. At 10:12 AM, E14 walked into R2's room and walked out and left for break

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without repositioning R2 off of her back. At 10:15 AM, E19 was asked to look at R2 and confirmed R2 had not been turned and could be up more. E19 stated R2's wound is "huge" and made the size of the wound with her hands at about cantaloupe size. E19 and E11 repositioned R2 and placed two pillows under her left side.

On 8/16/12 at 9:43 AM, E19, LPN, stated in an interveiw that R2 was readmitted to the facility on 8/7/12. E19 stated R2 did have orders but the treatments were not available and the treatment for her pressure sore wasn't done. E19 stated yesterday she did the treatment to R2 and the area was "huge" but did look better after the debridement. E19 stated the only dressing available was Silver Alginate and that is what she used on R2. E19 stated if the treatment record was circled that meant R2 didn't get her treatment and yesterday was the first day she got treatment.

On 8/16/12 at 10:00 AM, E11, LPN, stated in an interveiw that she did R2's wound treatment on the 8/9/12 and used Silver Alginate on R2's pressure sore. E11 stated that they have not received the Aquacel, Dakins solution and Versiva. E11 stated R2 was eating fair and had to be fed. E11 stated R2 drank well with a straw and she was unsure why her urine was dark as she was not being treated for a urinary tract infection currently. E11 stated she had some of the Silver Alginate left from her previous treatment and that is what she used.

R2 was observed for turning and repositioning and off-loading from her back. On 8/20/12 at 10:30 AM, 11:15 AM, 11:30 AM, 11:45 AM, and 12:15 PM observations, R2 had her face turned

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towards her right with a thin pillow under her left side At 12:20 PM, 12:30 PM, and 1:30 PM, R2 had her face turned to her left and she had a pillow under her right side. At 2:30 PM and 3:30 PM, R2 faced towards her right and she was lying on a pillow propped under her left side. On 8/21/12 at 9:15 AM, R2's face was turned to her right with two pillows under her left side, at 10:30 AM and 11:30 AM, R2 was facing slightly towards her left propped with two pillows under her right side. At 12:45 PM, R2 faced her right side with 2 pillows under her left side. On 8/22/12 at 9:05 AM and 10:30 AM, R2's face was slightly turned to her left and a thin pillow under her right side. At 11:00 AM, R2 was turned slightly to her right with a thin pillow under her left side. In all of these observations, there was no total offloading done to R2's back or buttocks.

On 8/22/12 at 9:55 AM, E19, LPN, stated that she worked as a treatment nurse on 8/8 thru 8/12 and the Aquacel and Versiva were not available. E19 added that she used the Silver Alginate which was R2 ' s treatment before hospitalization. E19 admitted that she did not call the physician but she did call the pharmacy on 8/10/12.

On 8/22/12 at 9:57 AM, E11, LPN, stated that she was doing treatments on 8/9/12 and just packed R2's wound with abdominal dressing and did not notify the doctor that the Aquacel Ag and Versiva were not available. E11 stated she can't recall R2 using the low air loss mattress until R2 came back from the hospital after debridement of her wound. On 8/22/12 at 1:00 PM, Z1 said that the low air loss mattress became available after R2 had the debridement. On 8/22/12 at 10:20 AM, E3, Care Plan Coordinator, stated that she did

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F9999	Continued From page 166 the treatments on 8/13/12 and the Aquacel Ag was available but not the Versiva. The Physician Order Sheet (POS) did not have any orders written between 8/8/12 and 8/15/12 for any treatment changes for R2. The POS dated 8/15/12 documented, "Discontinue all current treatment orders. Cleanse wound with wound cleanser - dry, apply Aquacel Ag, place 4 x 4 and abdominal dressing q day and as needed to coccyx and buttocks." On 8/22/12 the POS documented "May use Silver Alginate for coccyx wound (if Aquacel Ag is not available)". In a Wound Management Report dated 8/8/12, Z2 documents, "Stage IV pressure ulcer of the coccyx" with measurements of "13.5 cm long x 17.5 cm wide x 4.2 cm deep, tunneling at 12:00 for 3 cm". The report documents "bone noted at center". Z2 documents "Continue with current tx (treatment) plan at this time which is cleanse with Dakin's 1/2 strength, then apply Aquacel Ag and Mepilex dressing, change daily and prn". The report documents "currently washing the wound with Dakin's solution then treating the area with Aquacel AG and a Mepilex, which staff reports they are actually awaiting for those to be ordered. They are currently using a wet to dry dressing at this time". The Wound Management Report dated 8/13/12 documents Stage IV pressure ulcer of the coccyx. Z2 documents the current treatment as "cleanse with Dakin's 1/2 strength, then apply Aquacel AG and dry dressing, change daily and as needed". Z2 documented the wound as 13.7 cm x 15 cm x 4.5 cm with tunneling.	F9999		

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F9999	Continued From page 167 The Wound Management Report dated 8/22/12 documents a stage IV pressure ulcer of the coccyx with measurements of 13.5 cm x 13 cm x 3 cm with tunneling noted. Z2 documented to continue current treatment which is "cleanse with wound cleanser, apply Aquacel AG (may substitute any brand of silver alginate if Aquacel AG is not available) and then apply 4 x 4's to woundbed to fill in any extra space to promote granulation, cover with ABD, change daily and prn". Z2 also documented "We are going to try to obtain a wedge cushion at this time to help offload patient completely off her coccyx". On 8/22/12 the POS documented "Please use wedge cushion to offload pressure when turning side to side". On 8/20/12, at 9:15 AM, E11, Licensed Practical Nurse, LPN, assisted by E14, Certified Nursing Assistant, CNA, was observed providing wound care to R2. The dressing was dated 8/19 and was saturated with odorless, sanguinous drainage with yellowish brown material at the lower edge of the dressing. The wound was 13.5 x 14 x 4.5 cm with tunneling at 12:00 at 3 centimeters (cm). The wound bed had red tissue granulation, minimal yellow necrosis and bone was visible in the center. Some scattered areas of reddened fungal spots were noted around the wound and buttocks and back of thighs. E11 was observed cleansing the wound with a wound cleanser, patted dry with clean gauze, applied 3 pads of silver alginate, covered with 4 layers of 4 x 4 clean gauze, then applied abdominal dressing on top and secured the dressing with tape. The Silver Alginate did not cover the entire surface of the wound.	F9999		

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On 8/22/12 at 12:15 PM, E14 reported that R2 ate only 20% of her lunch and did not want to open her mouth anymore. In an interview with E11, she stated that the facility does not keep a meal monitoring record for R2, they just write in the Nurse's Notes if they can. R2's Nurses Notes dated 8/7/12 through 8/25/12 were reviewed and there was documentation regarding R2's meal intake on 8/22 and 8/25/12.

The Care Plan dated 7/24/12 documented R2 needed total assist of staff with feeding. The Care Plan documented as interventions to "Give resident as much time as possible to eat" and "document all meal % ate". The Care Plan did not address the significant weight loss of 14%.

R2's Care Plan on Potential for Skin breakdown dated 3/17/12 with last update on 4/25/12 that documented ,"noted open area to coccyx area", with the intervention "Santyl to coccyx QID". A copy of the Care Plan was requested and received from the facility the week of August 27, 2012. A request for the same Care Plan was given to the facility on 9/6/12 and the copy provided had added under the 4/25/12 notation an additional problem of "(outside wound consultant) to treat area to coccyx" which was dated 5/1/12. Additional interventions were added and dated 5/24, 6/6, 7/10/, 7/17, and 8/7/12. None of these interventions were on the original care plan obtained the week of 8/27/12.

In an interview on 8/22/12 at 1:00 PM, Z2 stated R2 was still waiting on getting her low air loss mattress on 7/17/12 and the wound had declined. Z2 stated the mattress became available when she returned from the hospital the last time.

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On 8/21/12 at 10:08 AM, Z3, Hospital Physician, stated over the phone that R2's wound had responded well the first time she was hospitalized. Z3 stated the facility didn't follow the order from the hospital. Z3 stated the second time she was admitted, which wasn't that long of time, it was "pretty bad" and "a lot worse". Z3 stated the facility either the facility wasn't monitoring the wound or changing her dressing as ordered.

R2 expired at the facility on 8/25/12.

2. R5's Minimum Data Set (MDS) dated 5/30/12, documents that R5 is totally dependent on the physical assistance of two staff members for transfers and bed mobility. R5 is totally dependent for physical assistance of one staff member for eating and dressing.

R5's POS dated August 2012 documents R5 has diagnoses, in part, of Scoliosis, Alzheimer 's Dementia and Chronic Stage IV Pressure Ulcer of the Mid back.

R5's Treatment Administration Record (TAR) dated November 2011,documents that on 11/4/11, R5 had a pressure ulcer to the mid back measuring 0.8 cm x 0.1 cm x 0.2 cm. An entry on 11/8/11 documents a pressure area on R5's right back, on 11/19 documentation refers to R5's right mid back, on 11/21 documentation refers to R5's right proximal back and on 11/27/11, documentation refers to R5's right proximal back. The Facility "Weekly Wound Report - Pressure" dated 6/7/12, documents that R5 has a pressure ulcer on the distal back measuring 5.5 cm x 5.1

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F9999	Continued From page 170 cm with no depth documented and it has "declined". A special wound consultant, Z2, began treating R5 on 12/5/11. R5's Wound Management Report, dated 12/5/11 documents and describes two wounds: a Stage III, midback proximal 1.2 cm x 0.8 cm x 0.3 with the woundbed 100%pink granulation; and an unstageable pressure ulcer of the distal mid-back 3.0 cm x 1.2 cm x necrosis. Z2 continued to see R5 weekly. Z2's note, dated 6/19/12, documents R5's pressure ulcer on the mid back as Stage IV, 5.1 cm x 4.4 cm x necrosis. R5's Wound Management Report, dated 8/22/12, documents that the area to the mid back measured 4 cm x 2.8 cm x 1 (tendon TUNNELING:12:00= 1.1 cm). All of R5's weekly wound consultant reports document "continue to offload pressure (from R5's back)". On 8/20/12 at 10:02 AM, R5 was in bed with her face turned towards her left but her back was not angled to the left. E11, LPN, assisted by E14, CNA, provided wound care to R5. E11 removed the dressing from R5's mid back. The dressing was moderately soaked with yellowish drainage. There was no date written on the dressing indicating when the dressing was last changed. R5's wound was observed and the tendon was visible with pink tissue granulation and very minimal necrotic area on the wound bed. R5's perineum wound was dry and scarring was noted. E11 cleansed R5's wound with normal saline, applied Silver Alginate and covered it with 4 x 4 dressing. On 8/20/12 at 10:30 AM, R5 was noted lying in bed, slightly turned to her left, her upper back	F9999		

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was lying directly on the bed, no off-loading of her back was noted. R5 was observed at 15 minute intervals, from 11:00 AM until 12:30 PM. R5 sat in the geriatric chair with a thin blue foam pad on her back with no repositioning observed. After R5's lunch, from 1:30 PM until 3:35 PM, at 30 minute interval observations, R5 sat in the gerichair in her room with the blue full length foam pad under her back.

On 8/21/12 at 9:15 AM, 9:45 AM, 10:30 AM, 11:05 AM, 11:35 AM and 12:45 PM, R5 was observed sitting in her geriatric chair in the hallway with no off loading of her back and no repositioning observed. In all of these observations, R5 had the blue foam pad on her back.

On 8/23/12 at 9:50 AM, R5 sat in the geriatric chair in the hallway with the blue foam pad on her back. At this time, E24, Physical Therapy Assistant, stated that the pad on her back was not a pressure relieving cushion. On 8/23/12 at 10:00 AM, E13 and E18, CNA's, stated they did not know that there was a specific cushion to put on R5 's back when she is sitting up in her chair.

The Physician Order Sheet (POS) for 8/20/12 documents "Up on geriatric chair daily for meals only. (Pressure Relieving) cushion for back of geriatric chair to offload pressure of back (4/4/12). Assure (Pressure Relieving) cushion is being used when resident is up in chair (4/18/12). Resident up only for lunch and dinner, maximum 2 hours at a time (6/6/12). Side to side turn only when in bed".

On 8/25/12 the POS documented "Remove blue

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full-length foam pad in geri-chair. Position pt. (patient) with (manufacturer name) back cushion while up in geri-chair during daytime activities. Pt. to wear B (bilateral) white foam elbow pads when up to geri chair".

R5's Care Plan for a Problem of Skin Breakdown was dated 3/7/2012. The Care Plan has not been updated and revised as of 3/7/12.

The undated facility Policy and Procedure entitled "Wound Care: Pressure Ulcer Mapping" documents, in part, "Identify Repositioning Needs: For bed at least every 2 hours, for chair every 1 hour. "

3. R1's History and Physical dated 7/23/12, documents diagnoses, in part, of Total Abdominal Colectomy due to toxic Clostridium difficile colitis. R1's Admission Nursing Assessment, dated 8/7/12, documents "Buttocks reddened". R1's admission Nurses Note, dated 8/7/12 at 10:30 PM, documents "Buttocks slightly excoriated".

R1's Care Plan, dated 8/21/12, identified R1 at a "High Pressure Sore Risk" with a Braden score of 9. The Care Plan did not document that R1 had any skin breakdown. One of the approaches documented for Skin Breakdown in R1's care plan is "Complete a full body check weekly. " There is no documentation in R1's clinical record that weekly skin checks were conducted.

The "Weekly Pressure Sore QI Log" for 8/8/12, 8/13/12, and 8/22/12 did not have R1 on the log. In an interview on 9/13/12 at 11:25 PM E1,

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F9999	Continued From page 173 Administrator, stated R1 was not on the Pressure Sore Log. The 8/7/12 hospital discharge instructions or "Discharge Medication Reconciliation with Patient Discharge Instructions" documented the orders for R1 as "Miconazole 2% Extra Thick (Secura Antifungal Extra Thick) perineum" every 12 hours and "Trypsin-Balsam-Castor Oil 60 Gm (grams) (Vasolex) Apply to Blister on Right abdomen, Bilateral Buttock ulcers, ulcer near rectum" every 12 hours. R1's Physician Order Sheet (POS), on admission to the facility on 8/7/12, "Miconazole Nitrate 2% topical cream every 12 hrs (hours) perineum area" and "Trypsin-balsam-castor oil 90 units-87 mg (milligrams)-788 mg- ointment (every) 12 hrs (hours) Vasolex-Blister Tx (treatment)". The POS dated 8/11/12, documents, "Vasolex to blisters of right side abdomen and close to the rectum bid (twice a day) 8 AM-8 PM". There were no other orders documented on the POS for the buttocks pressure sores. The "Treatment Administration Record (TAR)" dated 8/8/12 -8/31/12 which was obtained on 8/15/12, documented the treatments as "8/8/12 Vasolex apply to blister on rt (right) abd (abdomen) bilateral buttocks ulcers and ulcers near the rectum (every) 12 hrs (hours)" and "8/8/12 Miconazole 2% extra thick antifungal .. (every) 12 hrs (hours) to perineum area". The TAR documented the Vasolex was administered 1 time per day from 8/9/12 until 8/13/12. The Miconazole was started on 8/8/12 and administered only 1 time on 8/12/12 through the 15 th.	F9999		

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R1's TAR for August 2012 did not document any "Weekly Summary" for wounds. The information noted in R1's 8/7/12, 8/17/12 or 8/24/12 Nurses Note regarding the buttocks ulcers was not documented on the TAR "Weekly Summary".

The Nurses Note dated 8/17/12 at 2:20 am document, " Resident turned side to side due to ulcer on coccyx. Abdominal dressing changed and coccyx dressing changed per orders. "

R1's Nurses Note, dated 8/24/12 at 9:30 PM, documents "Buttocks pressure area appears more reddened, no odor noted, small amount of serosanguinous fluid with pinkish yellow slough noted, right fold and left fold of buttock, 5 cm long et 4 cm wide et with ragged edges noted at left fold - 4 cm long 13 cm wide will continue treatment as ordered. "

On 8/24/12 the POS documented "1. Cleanse wound, apply Bactroban, cover (with) dry dsng (dressing) daily and PRN (as needed) 2. Keep colostomy site clean and dry, apply anti-fungal cream around colostomy site. Skin prep edges around site. 3. Low air loss mattress". The TAR for August does not reflect these orders. The TAR does document for the Miconazole order "Dc'd (discontinued) 8/24/12". The TAR documented only one treatment of Miconazole done on 8/23/12 and none for 8/24/12.

R1's "Resident Transfer Form", was filled out by E19, LPN, dated 8/26/12, documents that R1 was transferred to a local area hospital due to shortness of breath. The Form did not document that R1's skin was impaired.

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F9999	Continued From page 175 On 8/29/12 at 9:16 AM, E19, LPN, stated that she was the nurse who transferred R1 to the local area hospital on 8/26/12 and stated that R1's buttocks was reddened and not quiet opened and there was treatment to it. E19 added that she can't recall when it opened. R1's Emergency Department Adult Initial Assessment dated 8/26/12 documents, in part, " Stage II Pressure Ulcer, Lower Back, 6 cm long and 10 cm wide, open area covered with white debree. " Pictures dated 8/26/12 provided by the hospital documented two stage 2 pressure ulcers on R1's right and left buttocks on both sides of the coccyx area approximately 6 centimeters long as documented by a "Wound Measuring Guide" in the picture. The area was open with white ointment appearing substance around the entire area. The actual pressure sore had a few spots of white substance in the wound. There was bleeding documented on the left outside portion of the wound. There was a third stage 2 pressure ulcer on the upper inner fold of the left buttock measuring 6 cm long by 1 cm wide. Hospital photo of R1's penis documented two small open areas on the tip of his penis. The area was red and white substance on the penis was documented. The emergency room report documented "Penis" and "red and open area/cover with white debree". 4. The facility Policy and Procedure titled, "Wound Care", with "Chapter 22" at the top documented in part, " Procedure: 1. Medical treatments must be documented on a treatment record in the resident's medical record. 2. The	F9999		

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nurse is responsible for administration and recording all treatments according to the physician's orders...Changes in the wound, refusal of treatment, anything unusual, or other pertinent information will be documented. This includes a total description of all decubiti, including size, depth, stage and drainage on a weekly basis and at any time a change is noted. The policy and procedure documented "The goal of this interdisciplinary team is to ensure the following: identification of high-risk residents, identification of the problem, nutritional adequacy, appropriate wound dressings, reduction of pressure, on-going evaluation and follow-up and prevention of wounds and pressure sores".

The facility policy and procedure section titled "Assessing Avoidable Versus Unavoidable Pressure Ulcers" documents "The facility must establish that it provided the care that was reasonably necessary to prevent the formation of pressure ulcers unless clinically unavoidable, and must institute prevention measures promptly for any individual identified at high risk for developing pressure ulcers. The policy and procedures documents "Before a pressure ulcer can be determined to be unavoidable, the following measures, and others if necessary, must be considered, implemented as needed, documented, and established as sufficient and reasonable to prevent the formation of pressure ulcers without success: A. Identify Risk on Admission...B. Identify Medical Conditions That Predispose Residents to Pressure Ulcers...C. Conduct and Document Ongoing Weekly Skin Assessments...D. Conduct Quarterly and Significant Change at Risk Assessment...E. Implement Care Planned Interventions

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F9999	Continued From page 177 Determine Routine Skin Care...Minimize Prolonged Pressure in Bed or Chair...Remove, Adjust or Relive other Sources of Pressure...Identify Repositioning Needs...Determine Continence Management...Evaluate Pain...Evaluate Nutrition/Hydration Status...G. Provide Collaborative Documentation...H. When Pressure Ulcers are Identified provide prompt care planning, notification to the physician and family and implementation of interventions designed to minimize or resolve the pressure ulcers...J. Treat with the Physician...". (A) 300.1210a) 300.1210b) 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	F9999		

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F9999	Continued From page 178 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) 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These requirements were not met as evidenced by:	F9999		

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Based on observation, interview and record review the facility failed to identify, evaluate, implement and monitor the use of siderails to prevent accidents for 3 of 6 residents (R13, R18, R21) reviewed for siderailes in a sample of 31.

The findings include:

1. R13 was originally admitted to the Facility on 11/29/09 with diagnoses, in part, of Senile Psychosis, Congestive Heart Failure and Type II Diabetes Mellitus. R13's MDS, dated 6/16/12 documents that she has short and long term memory problems; severely impaired cognitive skills for daily decision making; is totally dependent for transfers and all activities of daily living; and, does not ambulate.

On 8/21/12 at 1:45 PM, R13 was observed lying across her bed - her head on the window side and feet on the door side - with her head against her siderails. R13 was very active, wiggling her body all over her bed. R13's bed was equipped with bilateral 1/2 siderails located in the center of her bed. The rails were not padded. The top of each rail was attached to the bed frame. The bottom of each rails was not attached and wobbly. There was a 6 inch gap between the bed frame and the bottom end of each side rail. This was immediately brought to the attention of E15, Corporate Nurse. E15 said that she had noted a problem with some of the bed rails in the Facility the day before but had missed R13's bed rails. E15 said she would call hospice to come and get the bed. E15 confirmed that R13 moves her body

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F9999	Continued From page 180 all over the bed. R13's plan of care, with a beginning date of 4/21/11, documents a "Problem" of "Potential for Skin Breakdown". Included in the interventions for this problem is "1/2 rails to assist with turning and repositioning. Keep padded at all times while in bed". R13's "Side Rail Assessment" dated 6/6/12, documents that she is non-ambulatory, has fluctuations in level of consciousness, altercations in safety awareness due to cognitive decline, poor bed mobility and poor balance. The Assessment documents "At this time, side rails are indicated to provide safety". Written under the Comment section is the documentation "Padded siderails at all times". There is no medical reason for the use of the rails. There is no assessment of risks versus benefits for the use of the rails. According to the U.S. Food and Drug Administration (FDA) publication, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment - Guidance for Industry and FDA Staff", issued March 10, 2006; "to reduce the risk of head entrapment, openings in the bed system should not allow the widest part of the head to be trapped." The FDA uses a head breadth dimension of 4 3/4 incheses as the basis for its dimensional limit recommendations. 2. R21 was originally admitted to the Facility on 8/13/12, with diagnoses, in part, of End Stage Renal Disease, Hypercalcemia and Pericardial Effusion. R21's nurses notes, dated 8/19/12 document "6:45 PM, CNA was going down the hall and seen the resident laying on the floor with her feet on the rail and one foot underneath the	F9999		

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rail with the rail still up. This nurse assessed resident and resident has a hematoma to her right forehead and was laying on her right arm and complaining of pain to her right shoulder and left hip. Resident stated "she was trying to get something to spit in". Resident hand grips are unequal with right side weaker then the left side".

E33 stated in an interview on 8/29/12 at 4:00 PM she was passing trays on 8/19/12 and heard R21 call for help. E33 stated when she entered R21's room she could see R21's feet. R21 was between the bed and the window. E33 stated both feet were up in the air and one was tangled in the side rail. E33 stated the other foot was on top of the side rail. E33 confirmed the side rails were half rails in the middle of the bed and up when she found R21. E33 stated R21 told her she was trying to reach for her emesis basin and fell out of the bed. E33 stated R21 had a hematoma to the right forehead and she stated she had pain in the right side and head. E33 stated she called the nurse and they sent her to the hospital.

The "Incident Report" for R21 documents that on 8/19/12 at 6:45 PM, R21 "fell out of bed". The Report documents that R21 was utilizing 2 - 1/2 side rails which were in the raised position. The "Immediate Action to provide safety" documented on the Report documents "Resident was assisted by nurse and CNA back into bed and reapplied siderails". There is no assessment of R21's physical and cognitive function prior to being sent to the hospital on 8/19/12.

The "Resident Transfer Form" for R21 documents that she was sent to the hospital on 8/19/12 (no

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time given) for "Hematoma to right forehead and pain to right shoulder and right hip". A Medical Resonance Imaging (MRI) of R21's brain stem was conducted at the hospital on 8/24/12. The MRI documented "study is limited to patient motion. Right frontal scalp hematoma". R21 returned to the Facility from the hospital on 8/27/12.

On 8/28/12, at 3:20 PM, R21 was observed lying in her bed. R21's bed was equipped with a scooped low air loss mattress. There were 2-bilateral 1/2 rails located in the center of R21's bed.

On 8/29/12 at 1:25 PM, R21's bed was equipped with a non-scooped low air loss mattress with 2-bilateral 1/2 rails located in the center of the bed. The 1/2 rails were not secure at the end toward the foot of the bed. E15 was present when the bed was visualized. E15 confirmed that there had been a scooped mattress on R21's bed and E15 does not know why it was changed.

R21's "Side Rail Assessment", dated 8/13/12, documents "At this time, side rails are indicated to provide safety". The "Environmental Side Rail Assessment", dated 8/13/12, documents that 2, Full side rails are to be used. The word "No" is circled after the question "Do side rails function properly?"

3. A review of R18's face sheet documents that he was originally admitted to the Facility on 8/7/12, with diagnoses, in part, of Dementia and Anxiety. R18's Minimum Data Set (MDS), dated 8/14/12, documents that he is dependent on the

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limited assistance of one person for transfers and bed mobility, and requires the extensive assistance of one person for ambulation. R18's plan of care, dated 8/14/12, does not address skin integrity, cognitive status or activities of daily living. R18's plan of care is not individualized for Falls. R18's Care Plan for Falls documents that he utilizes a wheelchair for ambulation and has a personal alarm for safety. R18 was seen throughout all days of the survey sitting in his wheelchair or lying in bed with his bilateral full rails in the raised position.

On 8/29/12, at 9:55 AM, R18's bedrails were examined. R18's bed is equipped with bilateral siderails in the center portion of his bed. The rails begin 10 inches from the head of the bed and end 33 inches from the foot of the bed.

R18's "Environmental Side Rail Assessment" dated 8/7/12, documents that he uses "FULL" rails. R18's "Side Rail Assessment" dated 8/7/12, documents that "The resident is using side rails for positioning or support. At this time, side rails are indicated to provide safety".

R18's "Incident Report", dated 8/17/12 at 2:15 AM, documents that R18 "rolled out of bed". R18 was found "lying on right side on floor next to his bed, pillow under his head, bed pad and blanket under his body. No complaints, red area on right hip (old bruise on right hip), skin intact". The investigation is checked "NO" in the area documenting "were side rails present?"

R18's "Incident Report", dated 8/17/12 at 3:00 PM, documents "during rounds, resident noted lying on floor next to bed on right side - both of his

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siderails were in the up position. The floor was wet with urine. Small reddish area to left temple". The investigation documents that two full side rails were on R18's bed and in the raised position.

On 8/28/12, at 9:50 AM, R18 was seen sitting in his wheelchair in the front lobby. R18 pointed at his left hand with his right and stated "it hurts!" R18 then pulled on the bottom of the sleeve of his sweatshirt, trying to pull the sleeve up. R18's left hand was swollen at least twice the size of his right hand, and was dark blue and black. The bruising extended up his forearm to his elbow.

On 8/29/12 at 10:50 AM, several of R18's family members were visiting - including R18's Power of Attorney (POA), Z5. Z5 said that she first noticed R18's swollen, bruised hand "day before yesterday - it was turning black on Saturday (8/25/12)". Z5 said that R18 had deep ridges in his hand on 8/28/12. Z5 said "I wonder if he's getting all bruised up in the siderails".

There is no documentation that the Facility has R18 assessed for a medical reason, or risk versus benefits for the use of the siderails. In an interview with E1 on 8/28/12 at 10:49 AM, it was confirmed that the Facility has not assessed R18 for the use of the siderails.

(A)