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F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.650d) 300.661 300.690a) 300.690b) 300.690c) 300.1210b) 300.3240a) 300.3240b) 300.3240d) 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. (B) Section 300.650 Personnel Policies d) The facility shall check the status of all applicants with the Health Care Worker Registry	F9999		

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prior to hiring.

Section 300.661 Health Care Worker Background Check

A facility shall comply with the Health Care Worker Background Check Act [225 ILCS 46] and the Health Care Worker Background Check Code (77 Ill. Adm. Code 955).

Section 300.690 Incidents and Accidents

a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.

b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

Section 300.1210

b) The facility shall provide the necessary care

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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.

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)

d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)

These requirements are not met as evidenced by:
Based on observation, record review and interview the facility failed to identify and investigate injuries of unknown origin as potential abuse, failed to immediately report injuries of unknown origin to the Administrator and to the Department, failed to fully investigate injuries of unknown origin and failed to remove staff from direct care when involved in potential abuse incidents. The facility further failed to develop a written policy to ensure the facility investigates injuries of unknown origin and notifies the Department immediately after an allegation of abuse is reported, failed to operationalize it Abuse Policy by not reporting allegations of abuse immediately to the Administrator and allowing

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F9999	Continued From page 97 Certified Nurses Aides (CNA) to have direct contact with residents after potential incidents of abuse and failed to timely investigate injuries of unknown origin. This has the potential to affect all 73 residents living in the facility. Findings include: 1. The facility's Procedures of Prevention of Abuse, dated 1999 documented "Pattern Assessment: At least quarterly, the Quality Management committee will review concern identification reports, accident reports, incidents reports, missing items reports, and safety committee reports to assess possible patterns or trends of suspicious bruising of residents, unexplained accidents, or other occurrences that my constitute abuse, neglect or thefts. Based on an assessment of the reports, the Quality Management committee will further investigate and/or determine whether a change in facility practices is warranted." This policy did not address how the facility would immediately identify injuries of unknown origin, such as suspicious bruising of residents, as potential allegations of abuse. The facility's Procedures of Prevention of Abuse, dated 1999 documented under the section "Initial Reporting of Allegations: Within twenty-four hours after the occurrence, a written report shall be sent to the Department of Public Health." The policy did not address the Department should be notified immediately of all allegations of abuse. The facility's Procedures of Prevention of Abuse, dated 1999 documented "Protection of Residents	F9999		

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- Employees of this facility who have been accused of mistreatment will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator or designee. Employees accused of possible mistreatment shall not complete the shift as a direct care provider to residents."

The facility's Procedures of Prevention of Abuse dated 1999 documented "Employees are required to report any occurrences of potential mistreatment they observe, hear about, or suspect to the administrator."

The facility's Procedure of Prevention of Abuse, Section "Pre-Employment Screening of Potential Employees" documented "Prior to new employee staring a work schedule, this facility will: Initiate a reference check from previous employer (s), in accordance with facility policy; Check the Illinois Nurse Aide Registry on any individual being hired for a Certified Nurse's Aide position; and File an Illinois State Policy Healthcare Worker Background Check application on any individual being hired for a Certified Nurse's Aide position."

2. A review of the Physician's Order Sheet (POS) dated 12/1/12 for R4, documented diagnoses in part of; Hypertension, Diabetes, Arthritis and Alzheimer's Disease. The Minimum Data Set (MDS) dated 9/6/12, documented R4 was severely cognitively impaired. The Care Plan dated 9/6/12, documented R4 "has short term memory deficits. I am told things but do not remember, at times I do not even know where I am."

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In an incident report written by E36, Licensed Practical Nurse, LPN, and dated 7/20/12 at 10:10 PM, E36 documented; Called to R4's room by E37, Certified Nurses Aide, CNA.. Multiple bruising noted on inner thighs. 7.0 centimeter (cm) X 5.5cm bruise to right back rib area, 6.0cm X 3.5cm to right outer breast, and 6.0cm X 2.5cm to left back rib area. R4 last toileted at 10:00 PM. R4 stated, don't ask me what happened, I didn't know they were there." On 7/21/12, at 12:20 PM, E12, LPN, documented that "R4's daughter reported she had previously seen her mother scratching down there. She's on Aspirin and bruises easily." On 7/23/12 E3, Director of Nursing, DON, documented "E12 states the bruising matches R4's finger prints". The incident report documented no further information that an investigation had been done for this injury.

On 12/19/12 at 11:15 AM, in an interview E3, stated that she had reviewed R4's incident report of 7/20/12. E2 stated "R4's bruises were documented on the incident report and the report was put in my mail box. Since 7/20/12 was a Friday, I did not see the report until Monday 7/23/12. I thought the bruises were caused by R4 herself, since R4's daughter said she had been scratching between her legs. I did not investigate the rib and breast bruises for possible abuse of R4." E3 stated she would consider the bruises to R4's ribs and breast as bruises of unknown origin and stated "I did not know I had to do an investigation on bruises of unknown origin." E3 stated she did tell the Administrator about the incident/bruising of R4 on 7/23/12. E3 stated she did not know to notify the Department.

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3. R1's POS dated 12/1/12 documented a diagnoses in part of; History of Pancreatitis, Glaucoma, Osteomyelitis, History of Transient Ischemic Attacks, and Venous Insufficiency. R1's MDS dated 10/31/12 documented R1 was severely cognitively impaired, and was an assist of 2 staff for all mobility and hygiene needs.

Review of an incident report for R1, written by E14, LPN, was dated 9/5/12 at 11:45 AM. E14 documented "R1 was sitting at the dining table when bruises were noted on both hands by another staff member, E30 Registered Nurse, RN. E30 stated that the bruises were not there the day before." Measurements were documented as; Left hand between thumb and fore finger 3.5cm X 3.0cm and Right hand 4.0cm X 3.0cm. E3 documented on 9/5/12, skin fragile, bruises easily. Unable to state how occurred. The incident report documented no further information that an investigation had been done for this injury.

Review of an incident report for R1, written by E15, LPN, on 9/26/12 at 7:20 PM, documented, daughter came to nurses station to ask about bruise to left leg. Upon entering room, noted a 2.5cm X 3.0cm deep purple bruise to left outer calf and a 1.0cm X 1.0cm bruise to left outer ankle. Resident unaware of cause. The incident report documented no further information of an investigation being done for this injury.

On 12/19/12 at 11:15 AM, in an interview with E3, she stated that she did not do any further investigating of how R1's hands became bruised on 9/5/12 or how R1's left leg became bruised on 9/26/12. E3 stated "it's like I said earlier, the

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report was put in my box, and when I reviewed it, I was not aware that bruises of unknown origin had to be reported and investigated immediately. E3 stated "currently the facility has no system in place for reporting injuries of unknown origin immediately to the Administrator. Resident injuries are documented by the nurses on an incident report and put in my mail box for later review."

4. R2's Skin Issue Details Report dated 4/30/12 at 5:40 AM documented he had a 5 1/2 cm by 1 3/4 cm black and blue bruise on his upper left thigh. R2 was unsure how the bruise occurred. The Occurrence Report dated 4/30/12 documented R2's Physician and POA had been notified of the bruise. There was no documentation regarding if E1, Administrator had been notified of this bruise.

On 12/21/12 at 9:45 AM, an interview was conducted with E3. She stated there was no further documented investigation regarding R2's bruise of unknown origin.

5. On 12/18/12 at 4:00 PM, E2, Assistant Administrator was questioned regarding if the facility had any abuse allegations within the last year. E2 stated the facility had no allegations of abuse within the last year; however, an Investigation of Complaint was completed in November 2012. E2 again stated no allegations of abuse had been reported to her within the last year.

The Investigation of Complaint, dated 11/9/12 documented that at 5:00 AM, E2 received a telephone call from E32, LPN. E32 reported E31,

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Dietary Aide, was standing by the time clock and overheard someone say, "Shut up, be quiet, and I don't know." E32 stated E31 reported the allegation to her and stated the residents 'should not be talked to that way. It's not right.' The Complaint documented, "(E32) stated 'that is all I know, I do not know if it is abuse or not." The Complaint documented, " I (E2) told (E32) I would be in shortly to investigate the situation."

The Complaint documented E2 interviewed E32 regarding the incident. The Complaint documented, "(E32) informed me (E31) didn't really know but thought it was (E34, CNA) and (E33, CNA). At this time, I pulled (E33) and (E34) off the floor and informed them that someone thought they heard them say to a resident shut up, be quiet and I don't know. I instructed (E34) and (E33) to write up a statement of what happened." The Complaint did not document at what time E31 alleged the incident occurred.

The Complaint documented, "At approximately 0700, E3 and I (E2) interviewed (E32). When I asked (E32) what happened this morning she stated I was passing my meds on west hall and (E31) came to me and said she was standing at the time clock and heard someone say shut up, be quiet, and I don't know, and then they carried on with their conversation. (E32) stated ' (E31) asked me who the aides were on that side of the building and I told her (E34) and (E33) was helping. (E31) said something else about her mom being here, but I didn't catch all that, she also said that residents do not need to be talked to that way. So then I called (E2) to let her know what was reported to me.' I counseled (E32) if she though it may be abuse she should have

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pulled the 2 girls off the floor immediately. (E32) stated she wasn't for sure who even said what so I wasn't sure what to do that is why I called you."

There was no documentation regarding if this allegation was reported to the Department as an allegation of abuse. There was no documentation regarding if other alert and oriented residents were questioned regarding if they had any issues with staff treatment.

On 1/3/13 at 9:40 AM, an interview was conducted with E3. E3 stated basically E31 overheard a conversation between R37 and E33 and E34. E3 stated they did not conclude any abuse occurred; however, E3 did counsel E32 regarding not removing E33 and E34 from direct resident care after the allegation was made.

6. An incident report dated 9/5/12 at 11:45 AM for R1, written by E14, LPN, and E14 documented "R1 was sitting at the dining table when bruises were noted on both hands by another staff member, E30 Registered Nurse, RN. E30 stated that the bruises were not there the day before." Measurements were documented as; Left hand between thumb and fore finger 3.5cm X 3.0cm and Right hand 4.0cm X 3.0cm. E3 documented on 9/5/12, skin fragile, bruises easily. Unable to state how occurred. The incident report documented no further information that an investigation had been done for this injury.

7. Review of an incident report for R1, written by E15, LPN, on 9/26/12 at 7:20 PM, documented, daughter came to nurses station to ask about bruise to left leg. Upon entering room, noted a

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F9999	Continued From page 104 2.5cm X 3.0cm deep purple bruise to left outer calf and a 1.0cm X 1.0cm bruise to left outer ankle. Resident unaware of cause. The incident report documented no further information of an investigation being done for this injury. On 12/19/12 at 11:15 AM, in an interview with E3, she stated that she did not do any further investigating of the previous two incidents; of how R1's hands became bruised on 9/5/12 or how R1's left leg became bruised on 9/26/12. E3 stated "it's like I said earlier, the report was put in my box, and when I reviewed it, I was not aware that bruises of unknown origin had to be reported and investigated immediately. E3 stated "currently the facility has no system in place for reporting injuries of unknown origin immediately to the Administrator. Resident injuries are documented by the nurses on an incident report and put in my mail box for later review." 8. During tour of the facility on 12/18/12, at 9:40 AM, R7 had two small scabbed lesions to both shins and a purple bruise to the outside of her right knee. On 12/18/12, at 11:17 AM, Z1, family member was interviewed related to R7's care at the facility. Z1 stated, "She (R7) tries to crawl out of bed." Two half siderails were in the middle of R7's bed in the raised position. Throughout the day on 12/18/12, at 9:40 AM, 11:17 AM, 12:10 PM, 12:50 PM, and 1:55 PM, R7 was observed flexing and extending her lower extremities, and turning her lower body from side to side, often touching or resting them on the siderails.	F9999		

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On 12/19/12, at 10:55 AM, a skin check was completed for R7 with E13, CNA. E13 was interviewed and asked how R7 obtained the scabbed areas on her legs and the bruise to her right outer knee. E13 replied, "I don't know." E13 reported she was unaware the areas were there until now.

The Nurses Notes for 12/2012 fail to document any scabbed lesions to R7's lower extremities or the bruise to her outer right knee. The Treatment Record for 12/2012 has no documentation related to the scabbed areas to the lower extremities or the bruise to the righter outer thigh.

The Accident/Incident Log was reviewed for 11/2012 and 12/2012. No documentation related to the bruise or scabbed areas to R7's lower extremities is noted.

9. The MDS dated 10/31/12, documents R3 requires extensive assistance for bed mobility, transfers, and all activities of daily living (ADL's).

During tour of the facility on 12/18/12, at 9:40 AM, with E12, LPN, R3 was asleep in a reclined geriatric chair. Multiple dark purple bruises were noted to the top of R3's hands. E12 reported R3 had a recent fall from a wheelchair. R3 had flaccid paralysis of all extremities and facial muscles and was unable to communicate verbally.

On 12/10/12, the Nurses Notes for 12/2012 were reviewed. There was documentation in the Nurses Notes for December related to the current bruising of R3's hands. The Treatment Record for December 2012 was reviewed. There was no

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documentation in the Treatment Record related to the bruises to R3's hands.

On 12/20/12, the facility's Accident/Incident Logs were reviewed for 11/2012 and 12/2012. On 11/01/12, R3 fell forward out of her wheelchair, hit her head and was sent to the local hospital for evaluation. The Admission Nursing History/Assessment, dated 11/06/12, documents R3 was readmitted with purple bruises to both hands with edema and bruising around her left orbit (eye area). The Physician's Order, dated 11/12/12 documents Plavix (Clopidogrel), and antiplatelet agent was discontinued on 11/12/12 due to falls.

On 12/20/12, at 11:05 AM, E18, LPN was interviewed about the bruising to R3's hands. E18 stated, "I have not noticed them or seen them. I'm not sure with her." E18 did not go examine R3's hands and then wheeled the medication cart into the dining room.

10. On 12/20/12 at 3:00 PM, a review of E22's, E23's, E24's, E25's and E26's, Certified Nurse's Aides (CNA's),pre-employment screening was completed.

E22 was hired on 8/27/12 and the facility did not conduct a finger-print check to determine if she had any criminal history. E23, CNA was hired on 10/10/12 and the facility did not conduct reference checks with previous employers and a finger-print check to determine if she had any criminal history which would prevent her from employment. The facility did not conduct reference checks with previous employers for

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F9999	Continued From page 107 E24, E25 and E26 prior to their employment. On 12/20/12 at 3:25 PM, an interview was conducted with E27, Office Manager. E27 stated she read the Health Worker Registry wrong and did not conduct finger-print based criminal background checks on E22 and E23. E27 stated reference checks were not completed on E23, E24, E25, and E26. 11. On 12/19/12 from 4:15 PM until 4:40 PM, abuse prohibition interviews were conducted. E24 stated she would let the nurse and E3 know if she witnessed or became aware of an allegation of abuse. E25 stated she would let her Charge Nurse know if she witnessed abuse or became aware of an allegation of abuse. These employees did not state they would immediately notify E1 of an allegation of abuse. 12. The facility Abuse / Neglect Investigation Procedure documented; 1. The staff member who witnesses the suspected abuse will immediately notify the Administrator who will then launch an investigation per self or appointed staff. 4. The investigator will notify the Illinois Dept of Public Health per regulation of the alleged incident. 13. The Resident Census and conditions of Residents, CMS 672, dated 12/19/12 documents that the facility has 73 residents living in the facility. (A)	F9999		

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F9999	Continued From page 108 300.610a) 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 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:	F9999		

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F9999	Continued From page 109 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.1220 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)	F9999		

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F9999	Continued From page 110 These requirements were not met as evidenced by: Based on observation, record review, and interview, the facility failed to prevent pressure ulcers, failed to turn, reposition, provide pressure-relieving devices, and accurately assess 4 of 5 residents (R12, R7, R9, and R3) residents reviewed for pressure ulcers in the sample of 15. This failure resulted in facility-acquired Stage 3 pressure ulcer on R12's coccyx and two Stage 2 pressure ulcer on R12's buttocks. Findings include: 1. R12 was re-admitted to the facility on 10/18/12. Her History and Physical (H & P) dated 10/11/12 from the hospital documented diagnoses of Chronic Stasis Dermatitis and Chronic Cellulitis of the Left Foot, with weeping ulcers. On re-admission to the facility on 10/18/12, R12 had no pressure ulcers. Her admission Minimum Data Set (MDS) dated 10/24/12 documented no Pressure Ulcers. The facility's Weekly Pressure Ulcer Surveillance Report dated 10/31/12 documented no pressure ulcers for R12. On the 11/7/12 Weekly Pressure Ulcer Report, R12 had 2 pressure ulcers documented. The Report documented the ulcers as "nosocomial" (acquired in the facility). One pressure ulcer on the left buttock was described as Stage II, measuring 1 cm (centimeter) x 0.8 cm x 0.2 cm with a red center. The other pressure ulcer is described as Stage III, measuring 6.5 cm x 0.3 cm x 0.3 cm with red and yellow center.	F9999		

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The facility's current report dated 12/6/12 documented the left buttock has a Stage II, 1.1 cm x 0.5 cm x 0.2 cm, status is "deteriorated". The coccyx is described as Stage III, 1.1 x 0.5 cm x 0.2, "deteriorated."

On 12/21/12 at 10:12 AM, E16, RN (Registered Nurse), cleaned both wounds with normal saline. She applied a protective ointment to the buttock/coccyx area. A new area was noted on the right buttock. E16 stated, "That new Stage II on her right buttock was discovered on Wednesday (12/19/12)".

On 12/21/12 at 10:30 AM, E3, Director of Nursing, (DON) stated, "She (R12) is a high risk for pressure ulcers. She has chronic stasis ulcers on her legs, poor circulation, very low hematocrit and hemoglobin. She had to have 2 units of blood on Tuesday."

R12's Braden Scale dated 11/8/12 assessed her at a score of 12 which is high risk for pressure ulcer formation. Care Assessment Analysis summary dated 10/24/12 and Care Plan identified problem of potential for skin breakdown.

2. On 12/18/12 at 12:15 PM, R9 was seated in her recliner with her feet elevated on the footrest of the recliner. At 1:30 PM, E19 and E20, Certified Nursing Assistants. (CNA) assisted R9 in a transfer to her bed. E19 lifted R9's feet into the bed and removed her slippers and socks. R9's feet were both swollen. There was a dark, discolored area and redness noted on R9's right lateral ankle that blanched with pressure. R9 had redness on her right medial heel. On 12/18/12 at 1:45 PM, E16, RN, stated, "Her legs are not

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usually that swollen. Z2 (Physician), was here today and looked at her. He ordered a Doppler for her today to check the circulation in her legs."

On 12/19/12 at 9:15 AM, E16 examined R9's right lateral ankle. The swelling had improved but the area to the right lateral ankle remained a dark discolored area, resembling a deep tissue injury. R9 was seated in a recliner with the footrest up. The frame of the footrest was a hard metal with sparse padding that corresponded to the area on R9's lateral ankle when her feet rested on the footrest was elevated. E16 did not identify the area as a potential deep tissue injury, did not measure the area on R9's right lateral ankle.

R9 remained seated in the recliner with her feet elevated at 9:35 AM, 10:15 AM, 10:30 AM, 10:50:AM, 11:10AM, and 11:15AM. At 11:25 AM, E19 assisted R9 to ambulate to the bathroom using a wheeled walker.

R9's Braden Scale dated 12/17/12 assessed R9 as a low risk for development of pressure ulcers with a score of 21 (Score of 12 or less represents high risk.)

POLICY PROTOCOL:
The facility's Pressure Ulcer Prevention Protocol dated May 1992 stated (in part) that resident admitted or readmitted is to have a thorough skin check, any red/open areas measured and documented. "The skin will also be assessed for any pre-existing signs of deep tissue injury, such as a purple or very dark area that is surrounded by redness, edema, or induration." Residents at risk will have individual care plan developed.....Interventions could

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F9999	Continued From page 113 include.....individualized repositioning schedule, nutritional supplements, resident choices, special support surfaces....Residents will be monitored ..... daily report.....care plans will be modified to reflect current status. 3. The MDS, dated 10/31/12, documents R3 is severely impaired with cognition, requires extensive assistance for bed mobility, transfers, all activities of daily living (ADL's) and is incontinent of bowel and bladder. The Braden Scale, dated 11/27/12, documents R3 is a moderate risk for the development of pressure ulcers. On 12/18/12, at 9:40 AM, 11:20 AM, 11:47 AM, 12:15 PM, 12:23 PM, 12:30 PM, and 12:45 PM R3 remained laying on her back in a reclined geriatric chair without repositioning. At 12:50 PM, E10 and E11, Certified Nurses Aides (CNA) transferred R3 to bed. R3's pants and incontinent brief were heavily soiled with urine and feces. After incontinent care ws completed by E10 and E11, R3's rectal area was red. R3's left buttock was red, but blanchable. No barrier cream was applied to R3's perineal area. E11 stated, "That's the nurses job." R3 has flaccid paralysis to all extremities except for involuntary movements of her feet, flexing and extending repeatedly. On 12/19/12, at 8:55 AM, R3 was positioned on her back in a reclined geriatric chair. R3's heels were resting directly on the foot rest of the chair. R3 remained in the same position without repositioning at 9:10 AM, 9:25 AM, 10:00 AM, 10:25 AM, and 11:20 AM.	F9999		

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On 12/19/12, at 11:40 AM, R3 was wheeled into the dining room, awaiting lunch service. R3 remained in the dining room in the same position until 12:45 PM when E21, CNA assisted R3 to bed. On 12/19/12, at 12:50 PM, E21 was interviewed. E3 confirmed R3 had not been repositioned, and stated "You've been up too long." R3 had fecal smears on her incontinent brief. R3 had no barrier cream on her perineal area. R3's left heel had a large red area, but blanchable. R3 had a scabbed, Stage II area to her right inner buttock with surrounding erythema (redness).

R3's Care Plan, dated 11/06/12, documents R3 had a previous history of a Stage III pressure ulcer to buttocks in January of 2012. Approaches documented on R3's Care Plan do not address a turning and repositioning schedule or other pressure relieving interventions for her buttocks or heels. The Care Plan documents, in part, "(barrier cream) to buttock TID (three times daily) and PRN (as needed). Clean with soap and water."

The Treatment Record for December 2012, documents R3 has on 12/12/12, "coccyx- mild redness to buttocks. Free of breakdown", and on 12/19/12, "Mild redness to coccyx and buttocks."

The facility's policy and procedure, entitled 'Pressure Ulcer Prevention Protocol' documents, in part, "Residents who are considered at risk will have an individual care plan developed upon admission to remove/reduce those risk factors. Interventions could include, but not limited to, individualized repositioning schedule, nutritional supplements, resident choices, special support

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surfaces. If a resident is incontinent or skin is exposed to excessive moisture, routine pericare should be performed as per facility protocol, underpads or briefs can be used, periguard or other barrier cream should be applied."

4. The MDS, dated 10/10/12, documents R7 is moderately impaired with cognition, requires extensive assistance with transfers, bed mobility and personal hygiene, and is incontinent of bowel and bladder.

On 12/18/12 at 9:40 AM, 11:17 AM, 11:45 AM, and 11:58 AM, R7 remained in bed positioned on her back. On 12/18/12, at 12:00 PM, E10, E28 and E29, CNA's provided incontinent care for R7, briefly turning R7 from side to side. R7 had been incontinent of urine and feces. No redness or open areas were noted to R7's perineal area. No barrier cream was applied to R7's buttocks. At 12:10 PM, R7 was again positioned on her back. R7 remained positioned on her back, asleep at 12:50 PM, 1:10 PM, and 1:55 PM. At 2:40 PM, R7 was positioned slightly to her left side. R7 was extremely thin and emaciated.

On 12/19/12, at 8:55 AM, 9:22 AM, 10:00 AM, 10:25 AM, and 10:47 AM R7 was laying in bed on her back. On 12/19/12,at 10:55 AM, a skin check was performed with E13, Licensed Practical Nurse (LPN). A nonblanchable erythema (redness) Stage I pressure ulcer to R7's left sacral area was observed. In an interview at that time, E13 reported she was unaware of the area to R7's sacral area.

The Monthly Weight Record for 11/2012 documents R7's weight as 98 pounds.

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F9999	Continued From page 116 R7's Care Plan, updated 11/28/12, documents in part, identifies she is at risk for skin breakdown, with a history of gout to feet, bunion sores, skin tears and rashes. The approaches documented, in part, are "When I am less responsive, be sure my position is changed at times. (Barrier cream) apply to buttocks and coccyx TID" No interventions are documented for a repositioning schedule for R7 for pressure ulcer prevention. (B) 300.610a) 300.1210b) 300.1210d)6 300.1220b)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 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	F9999		

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F9999	Continued From page 117 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. 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 300.1220 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	F9999		

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F9999	Continued From page 118 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 requirments were not met as evidenced by: Based on observation, interview and record review the facility failed to identify causative factors contributing to falls, accidents and injuries; failed to implement interventions based on these identified factors; and failed to provide safe transfer techniques to prevent injury for 6 of 8 residents (R1, R2, R3, R4, R7, and R9) reviewed for safety/supervision concerns in the sample of 15. This failure resulted in R3 sustaining a left orbital and maxillary fracture. Findings include: 1. The POS dated 12/2012 documents diagnoses for R3, in part, of Dementia, Cerebral Vascular Accident, Altered Mental Status, and Mild Comminuted Fractures of the Anterior and Lateral Wall of Left Maxillary Sinuses. The MDS dated 10/31/21, documents R3 is severely impaired with cognition and decision making, and requires extensive assistance with transfers and bed mobility. The MDS documents R3's balance while standing or seated as unsteady. The Fall	F9999		

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F9999	Continued From page 119 Assessment, dated 11/06/12, documents R3 is a high risk for falls. The Incident/Accident Report dated 7/21/12 at 4:30 PM, documents R3's alarm was sounding and she was found sitting on her buttocks in front of her wheelchair without injury. The Investigation of Incident dated 7/21/12, documents R3's roommate reported R3 just slid out of her wheelchair. The interventions documented after the fall are, "Non skid applied to wheelchair cushion (top and bottom) cushion replaced in wheelchair. Staff instructed to keep in supervised area when up in wheelchair." The Incident/Accident Report, dated 11/01/12 at 12:30 PM, documents, in part for R3, "Sitting in wheelchair at nurses station, staff turned away to speak to a family member, turned back around and resident (R3) on the floor face down in front of wheelchair. Unresponsive for a few minutes." An ambulance was called at 12:45 PM, and R3 was sent to the local hospital for evaluation and treatment and was admitted (to the hospital). The Investigation of Incident, dated 11/01/12, documents R3's clip safety alarm was not sounding, and E12, LPN had turned around from the nurses station and got up to go to the supply room. E30, RN was passing medication by the nurses station and was speaking to a family member, turned and noted R3 on the floor. The Investigation documents, in part, R3 "Was sitting in supervised area. Clip alarm must have slid off." No intervention to prevent further falls is documented in the report or investigation of the fall.	F9999		

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The hospital's Acute Care Surgery Evaluation, dated 11/02/12, documents, in part, "fall from wheelchair at nursing home, is not accompanied by anyone and is nonverbal at baseline. Injuries to left face. CT (Cat Scan) of maxillary face positive, left orbital floor fracture, maxillary fracture."

The Nurses Note, dated 11/06/12, at 12:20 PM, documents, in part, R3 has "2 plus left eye hematoma, laceration above left eye with 2 sutures. No surgery at hospital."

On 12/18/12 and 12/19/12, R3 was observed in a reclined geriatric chair. R3 had flaccid paralysis to both upper and lower extremities, no trunk strength and had no verbal communication.

R3's Care Plan, dated 11/01/12, documents in part, "I do have a history of falls. I fell in the common area-to ER (Emergency Room), hospitalized. 11/06/12 returned with fracture left orbit." Approaches documented do not include the use of a reclined geriatric chair. An Approach documented is, "Observe me in my own environment for possible safety issues. Apply the appropriate precautions, sensor pad and clip alarm in my bed, recliner and wheelchair." Placing R3 in a supervised area is not documented as an intervention to prevent falls.

2. On 12/19/12, a review of R1's incident reports with E3, DON, was done. The reports are from 6/3/12 through 12/18/12 and documented the following injuries;

6/3/12 - While removing a clip alarm from R1's clothing, a skin tear was noted to her left arm. No

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further documentation of investigation or interventions was found in the report. E3 stated, The alarm was attached to the left sleeve of her gown, and I think R1 rolled on it in bed and cut herself. Staff should have placed it higher up on the gown to keep R1 from rolling on it. The care plan does not have documentation for this event. E2 stated she did not do any retraining on this issue with staff, just told them to watch where they place the alarm clips.

7/24/12 - Resident was being transferred by 2 CNA staff from wheel chair to shower chair. Left leg bumped into side of wheel chair (w/c) causing a 1.2cm by 1cm skin tear. No further documentation of investigation or interventions used was recorded on the report. On 7/25/12 the care plan documents the skin tear and "no new orders". E3 stated that she had read the incident report and if the care plan had no interventions documented then nothing had been done about the skin tear.

8/12/12 - CNA stated she was getting R1 up for the morning, from bed, and noticed a 1cm X 1cm skin tear to the left leg below the knee. The care plan documented 8/13/12, I have skin tear to left outer lower leg. No interventions / preventions documented. E2 stated she had reviewed the report, but no other interventions were initiated.

9/5/12 - Bruises noted by staff to both hands. Neither R1 or staff can say how bruises happened. Has fragile skin and bruises easily. The care plan has no documentation for this incident. E3 stated "if not written on care plan, nothing else was done.

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9/26/12 - Bruises found by family on left leg and ankle. The care plan documents 9/26/12, R1 sustained bruises to her left leg and a skin tear to her left arm. No interventions listed for this event. E3, stated she was aware of this report, but did nothing more than read the report.

9/27/12 - R1 sustained a 7.0cm X 3.0cm X 2.0cm elongated, jagged, flapped type skin tear to left arm with bruising. A written statement by E33, CNA, dated 9/27/12, documented that on the evening of 9/26/12, R1 was hanging her legs off of the bed and E33, had repositioned R1 back into bed on at least 2 occasions. E33 and E40, both CNA's, then did peri care on R1 in bed, rolling her back and forth during care, and after completing care, E33 noticed the skin tear on R1's arm. R1's care plan had no documentation for this incident. E3 stated she had reviewed the incident report, and determined the skin tear had probably occurred when staff were moving / providing care to R1.

12/10/12 - Noted to have a 5.0cm X 5.0cm purple bruise to right wrist and 4.5cm X 1cm bruise to left fore arm. No complaints, thin skinned, bruises easily. In a statement by E12, LPN, on 12/10/12, she documented that R1 was being transferred by mechanical lift, and attempted to grab the lift bar and hit her wrist, causing the bruise. E12 also documented that R1's bruise to her left arm was some how due to the strap of the lift, but did not specify how. E3, stated that she had reviewed the incident report, and agreed that R1's bruise to her right wrist was from grabbing at the mechanical lift bar and hitting herself on the bar. E3 stated she thinks the bruise to R1's Left wrist was some how cause because she got her arm

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pinched in the lift sling as R1 was being raised. The care plan documents this incident, but no interventions to prevent further injury to R1 during mechanical lift use are listed. E3 stated no further interventions were done.

12/18/12 - Son noted skin tear to R1's right elbow while lying in bed. E30, Registered Nurse, (RN) documented that she went to examine R1 in bed, and saw her lying with her arm rolled up in the sheet, and laying against the bed rail. R1 had a 1.5cm skin tear. The care plan documents the incident on 12/18 and treatment orders to clean and cover. No other preventions are listed.

On 12/19/12, in an interview with E3 stated that she was aware of all of the above incidents and had reviewed all of the reports. E1 stated that she had not realized that many of them had occurred when staff were caring for R1. E3, stated that although she had told staff generally to be careful with R1, she had not done any specific training or discussed further interventions with staff regarding prevention of further injuries to R1. E3 stated if it is not in the care plan, nothing more was done. E3 stated she is currently reviewing the 12/18/12 incident / skin tear of R1's elbow, but has not completed her investigation or decided upon an appropriate intervention as yet.

3. A review of the POS dated 12/1/12 for R4, documented diagnoses in part of; Hypertension, Diabetes, Arthritis and Alzheimer's Disease. The recent MDS dated 9/6/12, documented R4 was severely cognitively impaired. The most recent care plan dated 9/6/12, documented R4 "has short term memory deficits. I am told things but do not remember, at times I do not even know

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where I am."

A review of an incident report written by E3, DON on 10/2/12, documents; R4 was in restroom, states she fell forward and hit her face on the rack on the wall. 3 inch laceration to forehead, skin tear to nose, hematoma on right cheek. Sent to hospital for evaluation. R4 was trying to take herself to the rest room without assistance. Alarm was attached to chair, but not sounding.

A review of R4's care plan dated 9/15/12 documented the fall on 10/2, and that R4 had stitches and a dressing. Additionally the care plan included but was not limited to: I fell at home and fractured my right hip, my family found me sitting on the porch c/o pain and unable to ambulate, I can become confused and not know where I am, I will be free of avoidable falls by next care plan review. Keep call light in reach and remind me to use, staff will assist with mobility, remind me to lock wheel chair when getting up or sitting down. I will be observed in my own environment for possible safety issues.

On 12/19/12 at 10:30 AM, in an interview with E3 she stated, "R4 was found on the floor, and her alarm was not sounding. The maintenance director replaced the alarm." E3 stated "R4 does become confused and tries to walk on her own. R4 has poor safety awareness, but at this time R4 had no other measures for supervision to prevent falls other than those listed above in the care plan had been implemented.

4. R9 was admitted to the facility on 12/12/11. Her December 2012 Physician's Order Sheet documented diagnoses of Falls; Fracture Right

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Humerus, Tracheotomy, Hypertension, Chronic Obstructive Pulmonary Disease, Neuropathy, Parkinson's, Pneumonia. R9's Current Minimum Data Set (MDS) dated 12/5/12 assessed her as needing extensive assistance of one staff for bed mobility, limited assistance of one staff for transfer, ambulation, toilet use. Her balance is assessed as unsteady, unable to stabilize herself without staff assistance. Physical Therapy assessment dated 11/27/12 assessed her with abnormal gait and need to improve strength for transfers and gait.

R9 had several incidents of being lowered to the floor while being ambulated by staff. On 5/8/12 at 11:25 AM, she was ambulating with staff to the dining room and her knees buckled. There was no injury noted after this incident.

On 7/28/12 at 6:20 AM, R9 was lowered to the floor while being ambulated by a CNA. R9 complained of pain after this incident but x-rays were negative for fracture.

R9's Care Plan dated 10/31/12 does document she was admitted following a fall and fracture. The care plan states "I do not always call for assistance when I want to move/transfer myself", I am at risk for falls due to a history of impaired balance, unsteady gait."

On 11/21/12 at 8:15 PM, R9 was left unsupervised in the bathroom briefly while the CNA moved clothing off the floor. R9 stood up and fell to the floor, hitting her buttocks and shoulder. On 12/19/12 at 11:25 AM, R9 was observed in the bathroom ambulating with assistance using a wheeled walker. R9 had a

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large bruise on her left buttock. When asked how she obtained the bruise, R9 stated, "It's probably from when I fell the other day."

5. R2's Cumulative Diagnosis Sheet documented he had partial diagnoses of Parkinson's Disease and History of Falls.

R2's POS dated 3/2/2010 documented "Motion alarm while in bed to alert staff of res (resident) getting up w/o (without) help. Check placement and function Q (every) shift. Under seat w/c alarm to alert staff of res getting up w/o help. check placement and function Q shift. Clip alarm in w/c and bed to alert staff of res getting up w/o help. (Check) placement and function Q shift."

R2's Occurrence Report dated 2/6/12 documented R2 was found on the floor in his room. The Report documented "Heard alarm sounding - ran to room upon entering residents room noted resident on knees on fall-mat pushing magazines into night stand." The Report documented "Resident statement: 'I was trying to get up!'" The Section "Actions Taken" documented his care plan was updated and he had no pain when Range of Motion (ROM) was performed." R2's Care Plan was updated on 2/6/12 and documented the new approach "I need to call when I want things done c (with) my papers. I try to do things myself and end up on the floor."

R2's Occurrence Report dated 2/22/12 documented R2 was found lying on the floor on his left side in the hallway. The Section "Actions Taken" documented neuro checks were initiated, care plan updated, head to to toe body check and

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alert charting was initiated." R2's Care Plan was revised on 2/22/12 and documented "I was resistive to care and my UA Showed 3 + bacteria. MD does not want to treat until final culture received. "

R2's Occurrence Report dated 3/5/12 at 6:00 PM documented R2 was found on the floor in his room. The Section "Actions Taken" documented he had no pain when ROM was performed, his care plan was updated, staff conducted a head to toe body check and skin assessment, he was placed into bed, his alarms were applied, and his call light was available. R2's Care Plan was revised and documented "Use call light and ask for assistance."

R2's Falls detailed Report dated 3/23/12 documented that at 4:15 AM, R2 was visually observed on the floor and his alarms were sounding. R2's Occurrence Report dated 4/1/12 documented "As I entered the room, resident crawling across floor. Bed alarm & bathroom emergency light on. Seen resident at bathroom trying to pull himself up." The Occurrence Report documented R2's care plan was updated, and he was assisted into his wheelchair and placed at nurse's station. R2's Care Plan was revised and documented "I need to be patient with staff and wait til they answer before I try to do things on my own." After this incident, the facility did not revise the care plan with new interventions to reduce R2's risk of falling.

R2's Fall Details Report dated 4/2/12 documented at 5:47 AM, R2 was found sitting on the floor. R2's Occurrence Report dated 4/5/12 documented "I heard alarms coming from his

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room. Went down saw (R2) sitting on floor mat next to his bed. His back was to the bed." The Occurrence Report documented R2 was assisted by two staff and gait belt back into bed and his care plan was updated. R2's Care Plan was revised and documented "I am stubborn and like to do things on my own like I use to. I don't always call for assistance." After this incident, the facility did not revise the care plan with new interventions to reduce R2's risk of falling.

R2's Fall Details Report dated 4/4/12 documented at 12:55 AM, R2 was found kneeling beside his bed with his alarms sounding. The Occurrence Report regarding this incident dated 4/5/12 documented "as I came to res (resident's) doorway I say him kneeling beside the bed." The Occurrence Report documented his care plan was updated, he was assisted back to bed and explained the dangers of getting up without assistance. R2's Care Plan was revised on 4/4/12 and documented "I can get confused and unsure of the day and time." After this incident, the facility did not revise the care plan with new interventions to reduce R2's risk of falling.

R2's Fall Details Report dated 5/4/12 documented at 10:00 AM he was found kneeling on both knees beside his bed. The Occurrence Report regarding this incident dated 6/27/12 documented he experienced no pain with ROM was performed and he had pink colored knees. R2's Care Plan was revised on 5/4/12 and documented "Observe d/t (due to) found kneeling on floor." The facility's revised care plan did not address new interventions to reduce R2's risk of falling.

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R2's Fall Details Report dated 5/6/12 documented at 1:50 PM, he was found kneeling on his knees trying to tune the radio. The Occurrence Report regarding this incident documented "Alarms sounding upon entering room found resident on knees beside chair turning radio, assisted to standing position with two and gait belt and transferred back to bed." The Report documented R2 complained of no pain on ROM and had no reddened noted to knees. R2's Care Plan was not revised after this incident.

R2's Fall Details Report dated 5/15/12 at 2150 (9:50 PM), documented "bed sensor alarm sounding et (and) was called to res room by CNA. Res in R (Right) hip in front of toilet in bathroom . w/c (wheelchair) was on the other side of room. Clip alarm was on bed - fully intact. motion sensor did not sound until (staff) stood in front of it." The Report documented R2 complained of no pain with ROM was performed, a head to toe body check, alarm applied and was placed into bed. R2's Care Plan was revised on 5/15/12 and documented "I wanted to wash my face (and) ended up on the floor." The facility's revised care plan did not address new interventions to reduce R2's risk of falling.

R2's Incident Accident Report dated 5/19/12 at 1:50 PM documented "Resident semi sitting in room beside bed. Staff alerted by call bell alarm. No injuries noted." The Additional comments and / or steps taken to prevent recurrence stated "Has been reminded numerous times not to transfer self." The Investigation of Incident documented "Had been instructed by nurse to remain in bed p (after) catheterization until CNA would be there.

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Chose to ignore warning." R2's Care Plan dated 5/19/12 documented "I am very stubborn at times. Nurse asked me to wait for CNA to transfer to w/c." The facility's revised care plan did not implement new interventions to reduce R2's risk of falling

R2's Incident Accident Report dated 5/26/12 documented "Alarm sounding - when checked res noted to be sitting on buttocks on the mat next to bed." The Comment Section documented "Res (Resident) encouraged to use call light for assistance." The Investigation of Incident form documented "Res instructed numerous times not to self transfers but does on occasion. R2's Care Plan was updated on 5/26/12 and documented "I wanted to go to the bathroom." The facility's revised care plan did not implement new interventions to reduce R2's risk of falling.

R2's Incident Accident Report dated 6/24/12, he was found on the floor in his room and alarms were sounding. R2's Care Plan was updated on 6/24/12 and documented "I was confused and restless and unable to explain what happened." The facility's revised care plan did not implement any new interventions to reduce R2's risk of falling.

R2's Incident/Accident Report dated 6/29/12 documented at 6:15 AM "Resident was gotten up for AM, then was left in room to brush his teeth, next thing alarms was sounding. Found resident next to bed on knees, too far of a distant from room to nurses station to prevent from happening." The Investigation of Incident form dated 6/29/12 documented "Informed all staff, that he is not be left in room by self." R2's Care

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Plan revised on 6/29/12 documented "I was confused/disoriented and unable to make comment regarding incident." The facility's revised care plan did not implement any new interventions to reduce R2's risk of falling.

R2's Incident/Accident Report dated 8/16/12 documented at 6:20 AM," found resident in his bathroom on his knees in front of his toilet, ROM WNL (Within normal limits)" The Additional comments section documented "Instructed s staff - Do not leave in room by self when awake" The Investigation Of Incident form dated 8/16/12 documented "was just sleeping around 15 minutes prior to incident. All alarms sounded at the same time, except motion alarm did not sound - was sounding properly before that. May have crawled out of bed - under sensor/motion detector to bathroom on his knees- then was able to get up per self to set on toilet." R2's Care Plan was updated on 8/16/12 and documented "I like to do things on my own like I use to but I am physically unable to do anymore. I have BPH (and) sometimes have an urgency to go to the bathroom. I get embarrassed if I become wet so continue to remind me to ask for help." The facility's revised care plan did not implement any new interventions to reduce R2's risk of falling.

R2's Incident Accident Report dated 11/1/12 documented at 8:30 PM "Res found laying on his L (Left) side on the floor. The Investigation of Incident documented the alarms were present and sounding at the time of the incident. R2's Care Plan was not revised with any new interventions to prevent him from future falls.

On 12/21/2012 at 9:00 AM, an interview was

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conducted with E7, Care Plan Coordinator. E7 stated the facility utilizes different types of alarms to alert staff R2 is getting up. E7 stated R2 akinesia (loss of control of voluntary muscle movement) is worsening and most of his falls are in his room. A E7 stated the facility has tried a low bed, a bed-side mat on the floor and moving his bedside table. E7 stated in addition they have tried to re-educate him on asking for staff assistance which has been unsuccessful.

6. R1's Physician's Order Sheet (POS) dated 12/1/12 documented a diagnoses in part of; History of Pancreatitis, Glaucoma, Osteomyelitis, History of Transient Ischemic Attacks, and Venous Insufficiency. R1's Minimum Data Set, (MDS), dated 10/31/12 documented R1 was severely cognitively impaired, and was an assist of 2 staff for all mobility and hygiene needs.

A review of an incident report written by E18, Licensed Practical Nurse (LPN) and dated 10/27/12 at 14:45 (2:45 PM), documented that R1 was found on the floor in front of her recliner on her left side. The electric recliner was in a straight up position, and R1 had access to the control of the recliner. R1 was complaining of pain in her left shoulder, hip, and ankle. R1 stated "I slid out of my chair." The report documents that R1's physician was called and ordered X-Rays which documented a fracture of her left hip.

The report documented that on 10/27/12, E19 and E39 both Certified Nurses Aides, (CNA's) had toileted R1 at 1:00 PM and placed R1 in the recliner in the reclined position with the control in the pocket on the right side of the chair. At 1:45

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREESE NURSING HOME	**1155 NORTH FIRST STREET BREESE, IL 62230**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 133	F9999		

PM, R1 was still asleep in the recliner. The report documented that R1 found the recliner control and raised the chair too high, causing her to slide out onto the floor.

A review of the MDS dated 8/13/12, documented R1 was severely cognitively impaired, a BIMS score of 5 and did not walk. The care plan dated 5/30/12 documented an entry in the Fall category on 5/30/12, which read "I am more disoriented than I was in the past". Fall interventions were documented and included but not limited to; Staff will assist with mobility and ADL's, (activities of daily living). Observe me in my own environment for possible safety issues. Apply appropriate precautions.

On 12/19/12 at 1:30 PM, in an interview with E3, Director of Nursing she stated, that R1 had gotten the control out of the pocket of the chair on her own. R1 had poor cognition, was forgetful and very confused, and may not have been able to understand that she was raising the chair too high, or realize how to take her finger off the chair control. E3 stated that staff did not think to unplug the recliner to prevent R1 from falling until after R1 fell and fractured her hip on 10/27/12.

7. The POS for R7 in December 2012 documents diagnoses, in part, of Alzheimer's Dementia and Stroke Syndrome. The MDS, dated 10/10/12, documents R7 is moderately impaired with cognition, does not ambulate and requires extensive assistance with transfers and bed mobility. The Fall Assessment, dated 4/20/12 documents R7 is a high risk for falls.

On 12/18/12 at 9:40 AM, R7 was laying on her

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F9999	Continued From page 134	F9999		

back in a low bed with fall mats next to her bed. Two half siderails were in the center of her bed. R7 had several scabs areas to her lower extremities and a bruise to her right outer knee. R7 had her legs flexed with her feet flat on the mattress. R7 repeatedly moved her legs to the left, then to the right touching her knees to each siderail. R7 was wearing geriatric sleeves to both forearms.

On 12/18/12 at 11:17 AM, Z1 family member was interviewed related to R7's fall of 6/19/12. Z1 stated, "She's had one fall since she's been here. She had a personal body alarm on. She leaned over and fell out of her wheelchair." A non-skid rubber pad was resting on a pressure relieving cushion in her wheelchair. She tries to crawl out of bed at the foot end. She scoots herself down and out of the bed. It was my request to put the siderails in the middle of the bed."

The Incident/Accident Report, dated 6/19/12 at 8:30 AM, documents R7 fell forward from her wheelchair while sitting in the hall. R7's personal safety alarm failed to sound. The Report documents R7 suffered a 2 cm (centimeter) X 4 cm hematoma, a 1 cm X 2 cm skin tear to the left hand and a 2 cm X 4 cm abrasion to her left forearm, and was sent to the local hospital for treatment.

The Care Plan, updated 11/12/12, documents, in part ""Observe me in my environment for possible safety issues. Apply appropriate precautions." The Care Plan documents the fall of 6/19/12, but no intervention is documented for the fall until 7/03/12; "Utilize full lap tray when up-use only if able to utilize tray. Discontinued on 7/13/12."

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F9999	Continued From page 135 R7's Care Plan fails to address the use of half siderails in the center of her bed or the non skid rubber pad in her wheelchair. The Siderail Assessment, dated 10/16/12, fails to address the use of the two half siderails in the center of the bed, nor the risk versus the benefits of the use of the siderails. The Nurses Notes for December 2012 fails to address the small bruise to R7's outer right knee. The Treatment Record for 12/12 does not have documentation of the small bruise to R7's outer right knee. The Incident/Accident Report of 6/19/12 and the Nurses Notes for June 2012 do not document the intervention after the fall. The Report fails to document why the personal safety clip alarm was not functioning. The facility's policy and procedure entitled, 'Resident and Staff Safety' documents, in part, for the use of clip safety alarms, "Make sure that the unit is turned on and functioning properly prior to each use (when placing resident in bed or wheelchair and attaching the clip) Check the battery indicator light if the unit has one and change batteries as needed." (B)	F9999		