STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145939	A. BUILDING _____ B. WING _____	C 04/05/2013

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WATERFRONT TERRACE	**7750 SOUTH SHORE DRIVE CHICAGO, IL 60649**

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F 514	Continued From page 26 E19 (Medical Records) stated on 2-19-13 that the medical records are not all in place so sometimes I must look/search for the record in other places.	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a) 300.1010e) 300.1010h) 300.1010i) 300.1210b)5) 300.1210d)3)6) 300.1220b)2) 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 300.1010 Medical Care Policies e) All resident shall be seen by their physician as often as necessary to assure adequate health care.	F9999		

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F9999	Continued From page 27 h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a	F9999		

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F9999	Continued From page 28 resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements were not met as evidence by: Based on observations, record reviews and interviews the facility failed to assess and give medical treatments for 1 of 3 residents (R4) in the sample that sustained an injury (fractures) and	F9999		

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F9999	Continued From page 29	F9999		

failed to inform a physician of significant change of condition. R4 complained of pain for 2 weeks after being roughly transferred from the wheelchair to the bed. R4 was transferred to the hospital for further medical/surgical interventions with the current diagnosis of right hip displacement and left tibia fracture after complaining about pain and discomfort for a week.

Findings Include:

R4 was observed on 2-15-13; R4 was in bed stating that he was put into the bed rough and heard a popping sound from his hip and experience pain on his left lower side. Observations of R4's right hip were swollen, red and R4 stated he has pain upon moving in and out of his wheelchair.

R4 is a 47 year old male admitted to the facility on 12-5-12 with the diagnosis which includes diabetes mellitus, pressure sores, above the left knee amputation, and depression.

Review of the facility Concern/Complement Referral Form dated 2-1-13 notes the following, " reported resident concern of staff handling him roughly slinging him into bed and hurting his hip. Resident reported incident taking place on 3:00PM to 11:00 p.m. shift on 1-31-13."

The Concern/Complement Referral Form is signed by the Social Service Director and the Director of Nursing, DON. The Social Service Director and the Director of Nursing are no longer employed at the facility.

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F9999	Continued From page 30	F9999		

E1 (Director of Nursing) on 2-15-13 stated that the pervious DON handled the event(s) with R4 and there are no other or additional documentation for R1. E1 stated that she does not know why a concern from was done instead of a medical incident form.

E1 (Director of Nursing) stated on 2-19-13 that a medical incident form would have initiated medical attention for R4 not a concern form initiated by social service. E1 had no comments as to why a medical incident was not initiated instead of concern form from the social service department.

E12 (Nurse ' s Aide) stated on 2-19-13 at 3:30PM that she and another nurse's aide, E16 (Nurse's Aide) transferred R4 from his electrical wheelchair to the bed. After R4 was in the bed R4 began to complain about his hip. After about a week of hearing R4 complain to various people I spoke with E16 about the possibilities of R4 being seriously injured upon the transfer we did. I did not report R4's complaining of pain to anyone and I really do not know why I did not report it to anyone. R4 plays around a lot and I did not take R4 seriously. R4 is always crying wolf about something and I thought he was playing around and took his complaining as he was" crying wolf."

E16 stated on 2-19-13 at 4:00PM, she was unaware of R4's being in pain after assistance with a transfer. E16 also denies having any conversation with E12 about any pain or discomfort R4 was experiencing.

Z1 (Attending Physician) stated on 2-19-13 that R4 is always crying wolf. Something is always

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F9999	Continued From page 31	F9999		

wrong with him, but the moment the nurse called me about R4 experiencing pain from an incident I immediately gave orders for x-rays. I was not aware of this incident happening approximately 2 weeks ago. I was just informed the day I gave the orders of the incident.

Radiology report dated 2-19-13 notes: Left Hip: there is an acute appearing oblique fracture for the proximal femur with lateral displacement of the distal fragment. Right Hip: lateral and superior dislocation of the femoral head in relation to the acceptable noted.

R4 was transported to the hospital for treatment of his right hip displacement and his left leg fracture on 2-20-13, 2 plus weeks (20 days) after the initial incident on 1-31-13. R4 has complained to staff for 2 plus weeks about pain in his left side and right hip.

The facility's abuse policy notes as follows: Protection of Residents and Staff: Employees are required to report any occurrences of potential mistreatment, they observe, hear about, or suspect to a supervisor or the administrator.

E2 (Administrator) stated on 2-19-13 at 4:30PM that all of the employees in the building are required to report to the Director of Nursing or the Administrator.

E1 (Director of Nursing) stated on 2-20-13 at 10:00AM that all of the employees are required to report any and all occurrences to administration. E1 had no comments as to why E12 and E16 said nothing about R4's discomfort/pain for the past few weeks.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F9999	Continued From page 32 B 300.610a) 300.1210b) 300.1210d)3) 300.1220b)2)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. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: d) Pursuant to subsection (a), general nursing	F9999		

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F9999	Continued From page 33 care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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	F9999		

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F9999	Continued From page 34 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements were not met as evidence by: Based on observations, record reviews and interviews the facility failed to provide psychosocial interventions to prevent self-threatening/self destructive behaviors for two of 18 sampled residents (R4 and R1) reviewed for social service issues, in a total sample of 30. As a result of this failure, R4 is attempting to bite his fingers off because they are hard, black, dead tissue (gangrene) instead of surgical interventions and R19 is banging his head against the floor and wall to acquire staff attention for basic nursing care and treatment. Resulting in injury to his eyebrow and the need for a computed tomography (CT). Findings Include: On 2-19-13 at 2:00PM R4 was lying in bed biting and chewing the blacken portion of his fingers. R4 stated he refuses to allow the surgeon to amputate his entire hand. R4 stated he will bite and chew off the blacken portion of his fingers and than will keep his hand. 1). R4 is a 47 year old male admitted to the facility on 12-5-12 with the diagnosis which includes diabetes mellitus, pressure sores, above the left knee amputation, and depression. E7 stated on 2-19-13 that R4 has been biting his fingers, the blackened part, for quite a while.	F9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F9999	Continued From page 35	F9999		

Nursing notes dated 1-16-13 notes," right hand 2, 3, 4 and 5th digits which are fully blistered. Residents third digit is black in color, nail bed completely black, 3rd digit hard to touch."

Nursing notes dated 1-22-13 notes," frost bite appointment to see hand surgeon at hospital."

Nursing notes dated 1-31-13 notes,"resident states he is not having surgery on his hands. He is aware of the complications."

There is no documentation in the social service records related to R4 not receiving/accepting surgical treatment for his hand.

E1(Director of Nursing) stated on 2-19-13 that R4 is biting his fingers because he needs surgical removal of his hand because of gangrene. R4 refuses to get his hand amputated.

Review of the all of the social service notes for R4, there is no documentation that R4 received or was referred for psychosocial interventions from a psychiatric physician or any outside psychosocial programing to assist with acceptance with illness.

2). On 2-26-13 at 9:30AM, R19 was walking out of the dayroom into his room while pulling his pants down pointing to the toilet. R18 is unable to speak words just make sounds and points.

R19 is a 43 year old male admitted to the facility on 7-1-09 with the diagnoses which includes Down's Syndrome, profound intellect disability and legally blind, according his medical record.

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	145939	A. BUILDING _____ B. WING _____	C 04/05/2013

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F9999	Continued From page 36	F9999		

R19's care plan for Downs Syndrome (with no date) identified R19 self abuses whenever he wants attention/snack rewards. Resident removes his helmet and punches his eyes and head against the wall. Resident has socially inappropriate and or maladaptive disruptive behavior. The interventions to address the negative self/threaten behavior is as follows; remove resident from area, speak in calm voice when re-directing, reward positive behaviors, put radio head set on to calm resident and remove residents radio when he is on the floor.

Nursing notes dated 1-2-13 notes, R19 punches and scratches self...
Nursing notes dated 2-23-13 notes, R19 continues to hit himself to left eye.
Nursing notes dated 2-24-13 notes, resident continue to hit himself and his eyebrow remains swollen and no active bleeding.
Nursing notes dated 2-25-13 notes, told Z3(Medical Attending) of increase self abuse i.e. hitting self in the head with fist. New orders for a computed tomography (CT) with and without contract. Lab work and psychiatric evaluation.

Social Service notes dated 12-7-13 notes residents continues to self abuse and disrobe-robe. Self abuse for attentions and rewards.
Social Service notes dated 1-4-13 notes resident displays attention seeking behavior by lying on the floor.

E5 (Social Service Department) and E20 (Staff Nurse) stated on 2-26-13 at 2:30PM that R19 has always had inappropriate behaviors but lately

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	145939	A. BUILDING _____ B. WING _____	C 04/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFRONT TERRACE	**7750 SOUTH SHORE DRIVE CHICAGO, IL 60649**

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F9999	Continued From page 37 there has been an increase in his episodes. Z3(Medical Attending) stated on 2-26-13 at 3:00PM, R19 has been in the facility for a long time, but lately the nurses have told me that R19 has been having an increase in his acting out behaviors. I am not aware of alternative placement to better care for his mental and physical needs. I will discuss it with the facility. E5 stated on 2-26-13 at 2:45PM, I did not know of alternative placement for residents with mental retardation. I did not know about the levels or different skills needed to care for residents with a known diagnosis of Down's Syndrome. By the way, our social service director is no longer here, she quit a few days ago. B 300.1210b) 300.1210d)3)5) 300.1220b)2) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing	F9999		

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F9999	Continued From page 38 care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	F9999		

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F9999	Continued From page 39	F9999		

resident.

These requirements were not met as evidence by:

Based on record reviews and interviews the facility failed to prevent the development of a pressure sore for a resident who was admitted to the facility without a pressure sore and failed to care for the pressure sore in a timely manner which resulted in a Stage III pressure sore, for one of three sampled resident (R3) reviewed for pressure sore, in the total sample of 30

Findings Include:

R3 is a 82 year old female admitted to the facility on 11-14-12 with the diagnoses which includes hypertension, diabetes, dementia, peripheral vascular disease, left above the knee amputee (AKA) and right below the knee amputee (BKA), right hand contracture and cerebral vascular disease.

R3's nursing admission records dated 11-14-12 notes the following: old healed scar sacrum, left AKA and a right BKA. Nursing Skin Assessment: The Integumentary (skin) system notes: color pink, intact.

Z1 (R3's Attending Physician) stated on 4-5-13 at 10:00AM, that he cannot remember R3. Z1 stated that we must go by his admission notes about his care and assessment of R3.

Z1 (Physician) admission notes dated 11-15-12 notes the following, skin: Nursing Skin Assessment Reviewed. Plan for R3 is nutritional

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	145939	A. BUILDING _____ B. WING _____	C 04/05/2013

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F9999	Continued From page 40 support, skin care and fall precautions. Nursing notes dated 11-26-12 at 11:45AM notes the following: open area to sacral area, resident unable to explain what happen. R3's pressure sore is superficial and a stage II. Nursing notes dated 11-26-12 at 11:45AM notes physician called back made aware of occurrence, new orders. E16 (Treatment Nurse) Treatment records on 11-28-12 notes: slugging and necrotic tissue and a stage III. E16 stated on 4-5-13 at 9:30AM that her assessment was different from E30 (Staff Nurse) assessment on 11-2-13, 2 days earlier. E16 stated she requested an explanation from E30 because of the differences in characteristics of R3's wound. The vast differences were that R3's sacral pressure sore increased from a stage II to a stage III in 2 days. E16 gave no comments as to why and increase in characteristics of the pressure sore or the reasons as to why it developed in a short time (12 days) since admission. E1(Director of Nrusing) had no comments on 4-5-13 about R3's pressure sores B 300.610a) 300.1210a) 300.1210b)5) 300.1210c)	F9999		

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F9999	Continued From page 41 300.1210d)3)6) 300.1220b)2)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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)	F9999		

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F9999	Continued From page 42 b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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	F9999		

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F9999	Continued From page 43 Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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. These requirements were not met as evidence by: Based on observations, record reviews and interviews the facility failed to implement corrective and protective measures to prevent multiple falls to 1 of 3 sampled residents (R22) with multiple falls out of a total sample of 30	F9999		

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F9999	Continued From page 44	F9999		

reviewed for falls. R22 has had multiple falls, which resulted in an injury on the third fall (fracture of cervical). The facility also failed to have the correct amount of persons to transfer 1 of 3 residents (R25) reviewed for transfers with a mechanical lift in the total sample of 30. The incorrect transfer resulted in R25 being hit in the face with part of the lift causing an injury below her right eye to be swollen and red, black and blue with pain.

Findings Include:

R22 was observed on 2-19-13 on the skilled nursing unit sitting in his wheelchair unable to speak with his helmet on and requesting to go to bed.

R22 is a 87 year old male admitted to the facility on 8-3-12 with the diagnoses which includes dementia, difficulty in walking, injury to facial nerve and conjunctival hemorrhage.

Nursing notes dated 9-7-12 notes R22 was found on his knees beside his bed. R22 was unable to state what happened.

Nursing notes for R22 dated 1-27-13 at 1:30 a.m. notes the following: while attempting to elevate the head of bed resident fell back hitting his back, found by the nurse's aide on the floor calling for help.

X-ray result dated 1-27-13 notes: compression fracture of lumbar (L-1). Additional orders, transport to the hospital.

Care plan dated 8-30-12 to current notes: fall

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F9999	Continued From page 45	F9999		

screening done, and history of fall on 9-7-12 and 1-27-13. The plan is: prevention and to use safety devices/alarms on 1-28-13 and fall precautions, (The facility's Falling Star Program).

The facility's Falling Star Programs Policy notes 4). Individualized care plan will be initiated and immediate intervention will be put into place. 8). Recommendations and updating of individualized interventions will be implemented and documented on the resident's care plan.

Incident report dated 2-2-13 at 8:30AM notes R22 was found on the floor by his bed. when asked what happened he answered he attempted to get in the bed by himself.

Observations of R22 room on 2-19-13, no alarms on his bed, no pads on the floor for his low bed, no alarm on his wheelchair.

E23(Care Plan and Fall Coordinator) stated on 2-21-13 that R22 is always taking his alarms off of his bed and chair and does not follow directions. The pads on the floor beside the low bed are being ordered and have been off for the day. E23 had no comments as to why the care plan was not up-dated/re-assessed to prevent additional falls.

Z5(Attending physician) stated on 3-7-13 at 1:45 p.m. that the facility should have put in place the fall precaution program to prevent the second and third fall so further injuries and complications will be prevented. Z5 had no comments as to why the fall precaution program was not implemented after a history of falls and a serious injury.

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F9999	Continued From page 46	F9999		

E1(Director of Nursing) on 3-1-13 at 4:00PM had no comments why E23 did not discuss any problems related to fall prevention about R22 with her to stop R22 from falling. E1 up-dated the care on 3-7-13(after multiple falls with injuries), and arranged for additional equipment to aide with the prevention of fall for R22.

2). R25 was observed on 3-27-13 at 11:00AM, R25 was sitting in her wheelchair in the hallway with a blacken right eye which was swollen and red. R25 told surveyor that E21 was transferring her from the bed to the wheelchair alone. E21 hit me in the eye with the transfer belt and told me that she would take care of it and pay for any damage.

R25's Minimum Data Set (MDS) dated 12-31-12 notes the following: for transfers R25 is coded 3/3. Meaning extensive assistance and two plus persons for physical assist.

E21 explained on 3-27-13 at 2:30PM in the front office, this incident happen at 7:00AM prior to breakfast. I hit R25 with the buckle belt while transferring her from bed to chair. I did transfer her alone without any assistance. E21 gave no comments as to why she did not follow the assessment in place of R21, being a 2 plus person transfer.

E1(Director of Nursing) stated R25 transfer assessment was changed last month. The transfer assessment was not in the clinical records but on my desk. The reason for the change is because R25 does not need extensive assistance anymore based on her new assessments of 2-3-13. E1 gave no comments as

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F9999	Continued From page 47 to why this new information was not in the clinical records or why there was direct contrast with the current assessments for transfers. B 300.1610 j.)1)2)3) Sections 300.1610 Medication Policies and Procedures j. The contents and number of the emergency medications kits shall be approved by the facility's pharmaceutical advisory committee, and shell be available for immediate use at all times in locations determined by the pharmaceutical advisory committee. 1). Each emergency medication kit shall be sealed after it has been checked and efilled. 2). Emergency medication kits shall also contain all of the equipment needed to administer the medications. 3). The contents of emergency medications kits shall be labeled on the outside of each kit. The kits shall be checked and refilled by the pharmacy after use and as otherwise needed. The pharmaceutical advisory committee shall review the list of substances kept in emergency medications kits at least quarterly. Written documentation of this review shall be maintained. This requirement is not met as evidenced by: Based on observations, record reviews and	F9999		

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F9999	Continued From page 48	F9999		

interviews the facility failed to maintain the emergency medications in the emergency convenience boxes, failed to have emergency equipment in the emergency crash cart and failed to maintain the documentation of usage of medication and refilling of both emergency medications and equipment for all of the nursing units in the facility. This failure has the potential to affect all residents within the facility.

Findings Include:

On 2-26-13 at 6:30PM the surveyor accompanied by E1(Director of Nursing) made rounds on all of the nursing units, checking the emergency medication boxes and equipment (crash carts).

-The first floor the emergency medication box (convenience box) was open and medication was missing. There was no date when the emergency box was opened nor any written information of who the medication was given to and for what purpose.

E28 (Staff Nurse) stated on 2-26-13 that she was unaware that the emergency medications box was open and medication was missing. E28 also had no answer as to how long the the emergency medication box had been open.

E1 had no comments as to why the check list substances check form(emergency medications and crash cart list) was incomplete. The dates for 2-13-13 to 2-26-13 were blank.

-On the second floor of the facility (skilled unit), the emergency medication box was open in the medication room, there was no accountability of

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F9999	Continued From page 49	F9999		

the medication missing in the medication box nor was the pharmacy form filled out related to what medication was used, when it was used and which resident it was administered to.

2-26-13 at 7:00PM E27 and E28 (both Staff Nurse's) on the skilled unit stated, they were not aware of the open emergency medication box and did not know how long it had been open.

In addition, on 2-26-13 at 7:00PM there was no suction equipment, no suction machine, no intravenous tubing and no oxygen available on the emergency crash cart. At the time, E1 had no comments as to why the emergency crash cart was not in functioning condition to assist with life saving measures on the skilled unit.

-On the third floor, (the Alzheimer Unit's) the emergency medication box was open and a lot of the medication was missing. There was no lock and no written pharmacy form that tracks the medication that was used.

On 2-26-13 at 7:15PM, the emergency crash cart was empty. There was no emergency equipment inside of the cart. At the time E32 (Staff Nurse) stated she had no knowledge as to why the emergency medication box was open and who use it last and why it was used. In addition, E1 stated that in the recent past the emergency codes were done correctly because the emergency medication boxes and equipment were there for the resident, but the floor nurse just did not contact pharmacy to get a refill.

AW

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