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F 514	Continued From page 63 5. R9's MDS dated 4/28/13 identifies her to be interviewable with no cognitive impairment or memory deficits. On 6/11/13 at 3:05pm, R9, who was also identified by the facility as being interviewable, stated she had been treated for head lice. On 6/11/13 at 10:30am, E12, Certified Nurses Aide confirmed she treated R9 for head lice. R9's clinical record including the infection control log, Physician orders, nurses notes and progress notes for the past three months (March - 6/14/14) fail to reflect any information on treatment and/or monitoring for head lice. 6. On 6/11/13 at 12:02pm, R5 stated she was here 5 days and had to be treated for head lice. R5 also stated her room mate was also treated at the same time. R5 is one of the residents identified by the facility on admission as being interviewable. R5's clinical record including infection control log, Physician orders, nurses notes and progress notes for the past three months (March - 6/14/14) fail to reflect any information on treatment and or monitoring for head lice. On 6/14/13, the facility provided refutation for R5's claim of having and/or being treated for head lice stating that she was not here in March. According to E8, Medical Records on 6/11/13 at 2:10pm, she has not received training in medical records nor does she have a medical records consultant.	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a)	F9999		

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F9999	Continued From page 64 300.1210b) 300.1210d)3)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a	F9999		

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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 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements are not met as evidenced by:

Based on interview, observation, and record review, the facility neglected to have a system in place to accurately assess pressure sores, monitor for decline including infection/pain and change of treatment according to their policy for 2 of 2 (R1 and R10) reviewed for pressure sores in a sample of 11. This failure resulted in R1's left buttock pressure ulcer developing an

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infection/cellulitis and necrosis that requirement surgical debridement.

Findings include:

1. According to the Admission Record, R1 was admitted to the facility on 8/7/12 with diagnoses, in part, Bipolar, Hypertension and Anemia. The only wound reported on admission to the facility was an open area on her right ankle. Wound Reports dated 11/7/12 identify R1 as developing a left buttock wound on 10/28/13 that was first identified as a boil. Laboratory tests reviewed dated 2/21/13 document a Low Albumin of 3.0 (Normal 3.4-4.8) and a low Total Protein of 2.8 (Normal 5.6-8.3) on 3/22/13. R1's Physician's Order Sheet (POS) for May 2013 documents R1 received Arginaid 1 package twice daily (BID) along with House Supplements three times daily since 2/2013 and a daily vitamin, Thiamine, Vitamin C. The Care Plan dated 1/16/13 identifies R1's left buttock wound as a boil with interventions including Provide wound care, Document wound care, status, healing process in accordance with facility protocol, and assess/review nutritional needs among others but fails to reflect any specifics to the wound on R1's ankle and/or left buttocks and/or pain management associated with the left buttocks wound.

The weekly documentation for the week ending 3/6/13 documents R1's left buttock open area measured 2.0 cm (Centimeter) x 2.4 with no depth but having eschar. There is no staging identified and no further information recorded. A another skin condition report for week ending 3/7/13, (one day later), documents the wound measures 2cm x 3cm and is improving but

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neglects to include documentation or even identify the eschar present the day before. There is no explanation as to why there are two wound reports. For the week ending 3/13/13 (skin condition report), again, two reports documenting the same wound reflect different measurements: On the skin condition report - stage II 2.3 x .3cm treated with silvadeen and 1.2cm x 1.6, with 0.4 x 0.4 cm eschar and granulation - improving. None of the assessments are signed or indicate who did them. The facility nurses neglected to correctly document wound status that included not only measurements and location, but other essential wound information including stage, other characteristics of the wound such as color, odor, drainage, treatment, signs/symptoms of infections and pain if present on a consistent basis.

According to the "Other skin condition weekly Status Report" dated 3/20/13, R1's left buttock wound was again identified as a stage II measuring 1.4 x 1.5cm treated with Xenaderm and facility acquired. An "Other Skin Condition Weekly Status Report" dated 3/27/13 documents the left buttock as facility acquired, 1.4cm x 1.5c, treated with Xendaerm. A day later, for the week ending 3/28/13, an "Other Skin Condition Report" documents R1's left buttock wound as 1.8cm x 1.5cm with no depth, "S" (Slough) and granulation present and documented as "Stable." There is no stage recorded even though it has slough.

On the skin report dated 4/3/13, R1's left buttocks again measured 1.4 x 1.5 (same as 3/20/13) treated with Silvadeen. On 4/9/13, the Other skin condition weekly status report documents R1's left buttock as being present on admission, measuring 1.8cm x 1.6cm (same as 3/28/13)

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except with eschar present treated with Xenaderm. Status is documented as "regenerated" but a report dated the next day, 4/10/13, document the measurements as 3 x 2 1/2 "Xenaderm > eschar sloughing off" indicating a major increase in size. There is no staging documented. The nurses neglected to fully assess and document any other characteristics of the wound that included color, odor, exudate, signs/symptoms (s/s) of infections including peri-wound and/or pain if any. The wound sheets also conflict with whether it was in-house acquired or present on admission. This last evaluation identified R1's left buttock wound as facility acquired, not present on admission as the day before. The Physician is documented as being notified but no family. The Other Skin Condition Weekly Status Report dated 4/17/13 again measures R1's left buttock as 1.8 x 1.6 treated with Xenaderm but includes no other documentation as to the status/characteristics of the wound. The next week, 4/24/13 report documents R1's left buttock wound as twice the size being 2 1/2 x 3, again with no other assessment information being documented. There is no evidence the nurses evaluated R1's wound response to the current treatment for effectiveness given that the documentation shows gradual decline to this point.

The Treatment Administration Record (TAR) documents changes in orders: a new treatment was ordered on 3/6/13 for Hydrogel after cleansing the wound, cover with dry dressing once daily. On 3/8/13, this order was changed to apply Silver Sulfate after cleansing with normal saline(NS)/cover with a dry dressing until 3/15/13 when it was again changed to "cleanse lt (left) buttocks c (with) NS , apply thin film Xenaderm,

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apply skin prep to wound edges, apply DuoDerm every Mon (Monday) & Thurs (Thursday.) The nurses documented that the Xenaderm/DuoDerm dressing was done daily from 3/16 thru 3/25 then documented every Monday and Thursday except from 3/28/13 thru 4/1/13 when there is nothing documented except a "O" on 5/1/13 with no explanation. Again, from 4/8/13 thru 4/12/13, the treatment is documented daily. This treatment continued despite the decline in the wound status until 5/3/13.

On 5/1/13, R1's left buttock is identified as "degenerated" with measurements 2.5 x 3cm and "E" for depth. The nurse assessing R1's left buttock wound again neglects to include characteristics, odor, exudate, s/s of infection and or pain symptoms if present. Physician's Orders docment the treatment changed on 5/3/13 to Cleansing the left buttock with Sea Clens then applying Santyl daily but is documented done on 5/4/13, but not on 5/5/ or 5/6/13. The TAR documents both the old treatment of Xenaderm with DuoDerm documented along with the Santyl daily on 5/7 and 5/8/13 then only the Santyl done until she was transferred out on 5/10/13. On 5/8/13, the left buttocks is documented on a Pressure Ulcer Report sheet as a facility acquired, stage III, wound type "P" (pressure ulcer), measuring 2.5 x 5cm with 1/4 cm depth, slough and eschar noted with deterioration of the wound identified. There is no reference to infection and/or peri-wound status including pain. Z1, Physician, is documented as being notified and an order to send to the hospital for evaluation and possible debridement is obtained. There is no Physician's note regarding this order and no entry into the nurses notes explaining why R1's wound needed to be evaluated for debridement.

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The nurses notes dated 5/1/13 through 5/9/13 reflect only three entries regarding R1's pressure ulcers. The first is written by the Registered Dietician dated 5/6/13 in which the dietician's refers to the wound as a pressure ulcer. The other two nurses notes reflecting the pressure ulcers are dated 5/9/13: 7:19am - documents "resident is to be transferred today" to area hospital for "possible debridement of left buttocks. Daughter notified" and at 14:47 (2:47pm), "resident is schedule to go to" hospital for "evaluation on 5/10/13." There is no further documentation on wound status, pain and/or signs/symptoms of infection and no note as to when she actually was transferred from the facility.

The Hospital History and Physical dated 5/11/13 obtained on 6/13/13 documents that R1 was "admitted to the hospital through the emergency room because of signs and symptoms and findings consistent with the diagnoses of cellulitis as well as pressure sore on the coccyx and sacrum, more on the left buttocks area. The patient has swelling and redness and obvious infection on the left side with development of pressure sore which needed to be debrided surgically." The Emergency Department note dated 5/10/13 at 11:12am documents patient with c/o (complaints of) fever now resolved. "Per EMS, pt had temp (temperature) at NH (Nursing home). NH stated they did not take temp but rather pt felt hot to touch. Pt was given Tylenol po (by mouth), afebrile now." and "C/O pain to left buttock due to stage III pressure ulcer." The Physician's Documentation describes the area "The buttocks and sacral area reveals a 3.5 to 4cm round ulcer, stage III, with necrotic tissue at the base and

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margins." Admitting exam describes the wound as "pressure ulcer - unstageable" length 3 cm x 3cm with 1 cm depth. The Physician Note dated 5/10/13 at 11:15am documents that R1 presented with known pressure ulcer left buttock and fever.

There is no documentation in the nurses notes or pressure ulcer assessments that includes R1 exhibited a fever at any time and there is no indication she had complaints of pain as described in the hospital notes. Review of the Medication Administration Records (MAR) for the month of May 2013 documents no Tylenol being administered. The nurses notes neglect to record R1 being transferred to the emergency room and her feeling "Hot to touch" that was reported to the EMT's on transfer.

On 6/12/13 at 2:35pm, E13, Corporate Personnel and Previous Administrator identified the E18, former Director of Nurses (DON), as the nurses responsible for R1's wound assessments stating that she was employed from 11/5/12 thru 5/10/13 when she was terminated in part for failing to ensure that scheduled assessments were completed. According to E13, on 5/8/13 when E16, Nurse Consultant/Registered Nurse (RN), was informed R1 was being transferred to the hospital on 5/10/13 for debridement of a boil, a full assessment was done and E16 determined R1's wound was an unstageable pressure ulcer with E18's assessment being incorrect. On 6/13/13 at 9:10am, E13 agreed that the documentation for pressure ulcers was "horrible." On 6/14/13 at 10am, E1, Administrator stated that Z1, R1's physician/Medical Director, never voiced concern about R1's pressure ulcer care or steps would have been taken to transfer her to another facility. E1 also confirmed that Z1 was aware of

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her pressure sore.

E18 employee file was reviewed and she was found to have been counseled 12 times from 1/10/13 to when she was terminated on 5/10/13 for failing "to ensure scheduled assessments are completed, which can harm the operation of the facility."

On 6/12/13 at 2:50pm, E16 stated she questioned the assessments of R1's left buttock when informed that she was going for a debridement. E16 stated she immediately went to assess R1's area and found it to be blackish in color with slough present, no odor noted, "no drainage really" and not quite as big as a golf ball but bigger than a quarter. E16 stated she knew right away it was a pressure ucler and not a "boil" as E18 had referred to it at times. E16 stated E18 should have known it was a pressure ulcer. E16 acknowledged that incomplete assessments were done and that the area was infected. E16 also confirmed R18 had been counseled multiple times before R1's incident in regards to completing thorough, accurate and consistent assessments.

Interview with Z2, R1's family member, on 6/12/13 at 9am indicated that she was not notified that the pressure ulcer was bad until she was notified that she was going to the emergency room for evaluation on 5/9/13. Z2 stated that her siblings called her the week before going to the ER and said they could smell R1's left buttock ulcer and R1 repeatedly complained of pain when they were visiting. Z2 stated she called the facility at that time and reported the wound odor to a nurse but was told that it was normal and that the wound was getting better. Z2 could not identify

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who she spoke with but stated it was a male with a Jamaican accent. Z2 stated her mother had also complained to her on the phone in the weeks prior to the debridement that her "butt hurt really bad" and when reported to the nurse, was told that it was probably the sore on her bottom. Z2 stated she originally noted the left buttock wound at Christmas time and described it as small and scabbed over. Z2 said she talked with R1 daily and in the last week or so, her mother would complain that her "butt hurts her really bad." Z2 also stated that she was told when her mother was readmitted by facility staff that the "nurses here are not trained to treat severe bedsores" and that given it's an Intermediate Facility, R1 would have to be transferred to a skilled facility. Records document R1 as being transferred to another facility on 5/14/13.

The MAR's for March, April and May 2013 documents R1 had only Tylenol 325mg tabs two ordered by mouth every 4 hours as needed (PRN) for pain/fever and was never documented as being given during those 3 months. In addition, there is no evidence that pain management was considered in the wound therapy and is not included in the Care Plan.

On 6/12/13 at 2:05pm, Z1 was interviewed and stated he was "very familiar" with R1 and knows his residents very well. When asked if he was aware of R1's pressure ulcer on left buttocks, stated "yes, it was a stage I" and told the facility to use a padded dressing. Z1 stated there was no break in the skin at all when he last saw it. When questioned whether he was thinking of another resident since R1 had been admitted to the hospital for evaluation which resulted in surgical

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debridement on 5/10/13 based on facility and hospital records, Z1 insisted that he had sent R1 to the emergency room because she had been complaining of coccyx pain and they were not happy with him for doing so. Z1 advised to get the hospital records from the emergency room, that he was "a surgeon and very familiar with pressure ulcer treatment." Z1's progress notes from March 2013 thru 4/19/13 periodically refers to the ulcer but fails to include any characteristics of the wound or the status of it. There are no progress notes written after 4/26/13. Z1 is identified on the Hospital History and Physical dated 5/11/13 as the dictating physician and includes information on R1's pressure sore which "needed to be debrided."

The Facility's Policy and Procedure for the Treatment and Prevention of Skin Breakdown dated 5/13 documents the policy is to "properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for ulcer according to industry standards of care. The Purpose of the procedure is to "provide guidelines for the treatment of pressure ulcers to facilitate healing" and includes Key Procedural Points such as 1) Assess the pressure ulcers for location, size (measure length, width, and depth), sinus tracts/tunneling, undermining, exudate (amount, color, odor and consistency), odor, wound base characteristics (necrotic tissue, slough tissue, the presence or absence of granulation tissue), wound edge characteristics (epitheliatlization, erythema, edema, infuration, crepitus, pain, earmth, and/or maceration) and pain. The policy indicates that documentation of pressure ulcers

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will include at a minimum of weekly and when an ulcer is present, daily monitoring should include an evaluation of the ulcer, status of the area surrounding the ulcer, presence of possible complications such as signs of infections, whether pain is present, and when change is identified. A stage II ulcer, according to the policy, is partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough. The policy describes an "Unstageable" ulcer (page 8 dated 5/13) as "full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown.) and/or eschar (tan, brown, or black) in the wound bed. The facility neglected to provide accurate, complete assessments as to stage (unstageable) prior to her hospitalization and neglected to act when it showed signs of infections resulting in R 1 being hospitalized for a surgical debridement.

On 6/14/13 at 10 am, E1, E2 and E16 stated all nurses had been inserviced on pressure ulcers including assessment/documentation and monitoring and identified E3, Assistant Director of Nurses/License Practical Nurse, as being the wound nurse now. All three stated R1 was transferred out to a skilled facility due to her pressure ulcer on 5/14/13 as this facility is an ICF.

2. The facility failed to correctly identify, thoroughly assess, evaluate treatments and monitor R1's ankle pressure ulcer. According to admission records, R1 was admitted with an ankle ulcer on 8/7/12 which was identified as a stage I at the time. According to current wound sheets dated 5/8/13, it was determined to be a pressure ulcer stage II measuring 2 x 3cm

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pink/red "E" for Escar 80% with 20% granulation.

On 6/12/13 at 2:50pm, E16 stated she questioned the assessments of R1's ankle on 5/8/13 and reevaluated it herself determining at that point that it was a pressure ulcer. E16 stated that E18 was responsible for the wound assessments and E16 found them to be inaccurate.

Interview with Z2, R1's family member, on 6/12/13 at 9am indicated she saw R1's ankle ulcer on a home visit in December 2012 and described the wound as circular, with yellow around the inside of the edge and a "mucousy" plug in the center. Wound reports dated 12/25/12 identify the area as an acquired stasis ulcer on right ankle measuring 1.5cm x 1.5cm "stable" with no additional documentation. The assessment fails to identify who completed it.

On 3/6/13, the wound sheet documents R1's right ankle area as 1.4cm x 1.2cm with no depth and improving. On 3/13/13, the weekly wound sheet documents it as measuring 1.2cm x 1.4 with eschar but improving. One week later on 3/20/13, the wound record identifies it as a stage I measuring 1.8cm x 1.5cm with Silvadene as the treatment. The treatment remains the same and on 4/24/13, according to the weekly wound sheet, R1's right ankle measures 2cm x 3cm with no other documentation present. On the 5/1/13 weekly wound sheet, R1's ankle documents another decline measuring 2.5cm x 3cm with Eschar (no othe documentation on the characteristics of the wound). The treatment remained the same from 1/11/13 and read "Silver Sulfate Cream 1%" apply to rt (right) ankle ulcer & apple drsg (dressing) once daily until R1 was transferred out to the emergency room on

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5/10/13.

The May 2013 TAR documents no initials as treatments done on R1's ankle from 5/5/13 through 5/10/13 when R1 left the facility.

The facility failed to adequately assess R1's ankle wound to include all characteristics of the wound and failed to re-evaluate the course of treatment when the wound didn't improve but declined with eschar present.

On 5/14/13, a change in treatment was done and Santyl, a debriding agent was ordered.. The Weekly Wound sheet dated 5/14/13 identifies the wound as a ulcer measuring 2cm x 2cm. but no other wound characteristics even though E16 indicated that all nurse were inserviced on pressure ulcer/wound documentation.

According to the Pressure Ulcer Policy/Procedure, a stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough. (Page 7 dated 5/13) An Unstageable ulcer is described (page 8 dated 5/13) as "full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown.) and/or eschar (tan, brown, or black) in the wound bed.

3. According to the MDS dated 5/15/13, R10 is dependent on staff for all activities of daily living and is a double amputee. Laboratory tests reviewed dated 9/24/12 identify a normal albumin and total protein. The Skin Condition Weekly status report dated 6/12/13 identify a coccyx wound with no measurements but identified as "stable." The wound type is identified as "other." The report is unsigned and has no further wound

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characteristics identified. A Progress note dated 6/12/13 was provided during refutation on 6/14/13 and identified the wound location on the coccyx, unmeasureable, slightly raised bed, with no drainage, odor, stage or comments. The documentation does not reflect the pinpoint area nor the redness of the peri-wound.

On 6/13/13 at 9:36am, R10's coccyx area was observed with E2, Director of Nursing (DON) in attendance. R10's coccyx was reddened/shiny (circular) with some scarring and a small pinpoint open area in the middle. No drainage or odor was noted. The wound documentation/report failed to reflect the pinpoint open area and the redness/size.

According to E16 all nurses were inserviced on accurate, complete assessments after 5/10/13.

(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

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procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

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

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

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F9999	Continued From page 80 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. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on record review and interview, the facility failed to provide adequate supervision for falls and self injurious behavior (head banging); failed to have a system in place to assess causal factors for self injurious behaviors; failed to implement and monitor the effectiveness of interventions for self injurious behaviors; failed to have a system in place to ensure interventions	F9999		

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are implemented correctly and consistently; failed to seek an evaluation for injuries caused by self injurious behavior for 2 of 2 residents (R3 and R1) reviewed for falls and self injurious injuries in the sample of 11. This failure resulted in R3 being hospitalized for a chronic and acute subdural hematoma requiring brain surgery and partial skull removal for swelling in the brain.

Findings include:

1. R3's Admission Sheet documents R3 was admitted to the facility on 11/11/11 with a diagnoses, in part; Huntington's Chorea, Epilepsy and recurrent seizures and Schizoaffective Disorder.

Skull Series Exam of 11/07/11, that was done before R3's admission to the facility documents, "Examination reveals no evidence of fracture."

Physician Document Report/Operative Report of 1/4/13 documents date of procedure as 1/3/13. Preoperative diagnosis: Large right subdural hematoma both subacute and chronic in appearance. Postoperative Diagnosis: Large right subdural hematoma both subacute and chronic in appearance with cerebral edema. Procedure Performed: Right frontal temporoparietal craniotomy and evacuation of subdural hematoma with extensive membrane removal and the bone was left out due to cerebral edema. Comment: The patient is a 49 year old right-handed white male, who has had numerous falls most likely contributed to by his Huntington chorea's constant falls and some self mutilation with banging of his head against the wall. He now comes with progressive lethargy...There is also an abrasion on his scalp with blood extruding

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from the abrasion...Computerized tomographic scanning of the brain reveals a large right sided subdural hematoma with significant mass effect and chronic and subacute appearance with isodense component also. At this time due to the significant shift and history of deterioration, although difficult to ascertain due to the progressive advanced Huntington's chorea clinical picture, surgical intervention was offered as an option...It was necessary to dissect membranes because this clearly was a chronic condition with loculated fluid collections needing evacuation...Due to the patient's young age, it was felt the bone should be left out in order to accommodate any possible swelling.

Facility Fall Risk Assessment's of 11/24/11 through 1/2/13 document R3 scored above 10 which is a high risk for falls.

Nurses Notes from 11/11/11 thru 1/2/13 document R3 fell 12 times during his stay at the facility.

On the afternoon of 6/12/13, E13, Corporate Administrator, provided copies of R3's Incident/Accident investigations stating that these were the investigations for R3 from admission to discharge. There were no incident investigation for the fall of 3/14/12.

R3's Nurses Notes document on 11/15/11 - R3 was observed standing up from the wheel chair and falling to the floor and hitting the left side of his head. Pressure dressing applied. R3 was sent to the ER (Emergency Room) and received 7 staples to the left side of his head.

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R3's Nurses Notes document on 3/14/12 - R3 seen on patio by CNA (Certified Nurse Aide), R3 states he lost his footing - put his hands down and bumped his lips. Has small slit to upper and lower lip. Slight redness. Few drops of blood. Note of 3/17/12 documents X ray was ordered per brother's request to bilateral upper extremities. X-ray results showed no signs of fractures.

R3's Nurses Notes document on 8/29/12 - R3 was noted ambulating with an unsteady gait toward patio door ambulating thru the dining room for a cigarette. R3 bump and tripped over his feet and hit forehead on right side of facial orbital on patio door.

Incident/Accident Report/Fall Investigation Report of 8/29/12 documents that facility will, "Anctipate needs, offer assistance with ambulation." Care Plan approach attached to the incident report documents fall on 8/29/12, R3 refuses to accept assistance and should be encouraged to accept assistance with ambulation. "Anticipate needs - offers assistance with ambulation."

Nurses Notes of 9/16/12 document - R3 on patio and went to sit down in a chair and missed the chair and fell on buttocks sustain abrasion on his left elbow. Portable X-ray done. (There is no further follow up in the Nurses Notes documenting the result of the X-ray.)

Incident/Accident Report/Fall Investigation Report of 9/16/12 documents that facility will "Anticipate needs - R3 encouraged about safe sitting." The Care Plan approach attached to the incident report documents, "CNA will be inserviced to

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ensure R3 is well sitted in patio during smoking time. Anticipate needs. Encouraged about safe sitting practice." The Care Plan for R3, that was provided from the facility as R3's Care Plan from admission to discharge has the statement, "CNA will be inserviced to ensure R3 is well sitted in patio during smoking time" appears to have been altered/whited out (removed from the Care Plan).

R3's Nurses Notes of 9/19/12 document- R3 tripped and fell on his way from the smoking patio to the Dining Hall according to him. He sustained a laceration to his chin. Some bleeding noted from the laceration. Ice pac applied to stop the bleeding. Neuro checks. Sent to ER. Returned with 11 stitches to his chin.

Incident/Accident Report/Fall Investigation Report of 9/19/12 documents, "Facility will place small ramp between door way and flat flore surfaces. Will continue to monitor and offer assistance with ambulatory and transfer." Care Plan attached to the Incident Report documents, "Continue to attempt to educate fall risk and safety. Facility will place small ramp space between Patio & dining entry on floor surface." The attached Care Plan also documents under potential for fall due to "Ambulation unstable" and Diagnosis: "Huntington Diseise, Seizure." This is not on the Care Plan that was provided to Surveyor as R3's Care Plan from admission to discharge.

R3's Nurses Notes of 10/14/12 document - Social service observed R3 entering the Dining Room walking quickly and unsteady. Before social service could approach R3, R3 lost his balance and dropped to his hands. R3 immediately got

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F9999	Continued From page 85 back up and after several more steps dropped again to his hands. Incident/Accident Report/Fall Investigation Report of 10-14-12 documents that the facility will review labs and medication per MD (Medical Doctor). Care Plan attached to report documents, "R3 had a fall r/t (related to) the use of psychotropic medication. hh/x of fall and he has a d/x (diagnosis) of HUNTINGTON DISEASE, SEIZURE." Care Plan Goal is, "R3 will have no major injury related to fall." Interventions are, "Educate resident to slow down during ambulation. Date initiated 10/14/12. Order for helmet. Date initiated 10/14/12. Refer to social service. Date initiated:10/14/12." R3's Nurses Notes of 12/13/12 document - Social Service states she was in the Dining Room and she saw R3 unsteady and dropped to the floor on his hands and knees. R3 got up by himself and went to his room. The Nurse went to the room and assessed R3. Incident/Accident Report/ Fall Investigation Report of 12/13/12 documents, "R3 referred to social services for behavior intervention. R3 noted with this behavior in the past." Care Plan attached to the Investigation Report documents, "R3 may intentionally fall due to misconception and confusion." Care Plan Goal documents, "R3 will not exhibit such behavior." Care Plan interventions are, "Encourage R3 to clarify misconception with Staff. Staff will educate R3 on danger of such behaviour. When R3 is observed confused during meds Pass, Staff will immediately clarify any confusion per medicine."	F9999		

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R3's Nurses Notes of 12/22/12 at 11:55PM, documents - R3 was standing in the Hallway and became combative and lost his balance and fell on buttocks. No apparent injury.

Incident/Accident Report/Fall Investigation Report dated 12/21/12 for the above fall shows no documentation for additional comments/interventions but does document that shoes appear to be too big. Care Plan approach was added, "Evaluation for appropriateness of footwear."

Nurses Notes of 12/30/12 document - CNA told nurse she saw R3 fall back in the smoking patio hitting his left elbow on the ground. Vital signs were taken and R3 stated he had no pain during assessment.

Incident/Accident Report/Fall Investigation Report of 12/30/12 documents R3 stated he tripped on peer. The report documents no additional comments/interventions. The Care Plan approach was added to encourage R3 to sit during smoking times.

Nurses Notes of 1/2/13 at 7AM documents - R3 fell in the main dining room fell on his hands and knees. This was around 4:55AM. No injury sustained. At 6:55AM, R3 fell again. Noted injury to left eye brow and left side of face. Gait very unsteady. Z3, Brother and Z1, R3's Doctor, notified. R3 had a 3rd fall while awaiting a call back from Z1...R3 will be transferred to Hospital for evaluation. Neuro check in progress.

Incident/Accident Report/Fall Investigation Report of 1/2/13 documents under comments, "While

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waiting to be transferred to hospital pt (R3) fell. Typed note added to the report on a separate sheet of paper dated 1/3/13 documents, "Administrator and ADON (Assistant Director of Nursing) watched video of dining room on 1/2/13 at 6:18am. R3 tripped over dining room chair and hit the right side of his head twice on the floor. Witnessed by R11, another resident."

Nurses Notes reviewed from 11/11/11 thru 1/2/12 document two notes addressing R3 using a helmet. Documentation on 3/31/12, "R3 refuses to wear helmet and family does not want him to either. Wants to make R3 feel he is in control of his balance. R3 is resistant of care @ interval. Has to be redirect & consel on why he needs assistance." Note of 10/27/12 documents, "R3 was also hitting his head on the wall, However he has head gear on." During meeting on 6/14/13 At 10AM, E13 (Corporate Administrator), who was the facility Administrator while R3 was at the facility, and E16 (Corporate Nurse) both stated the facility did not do a comprehensive evaluation for the use of the helmet.

MONTHLY SUMMARY Nurses Notes for March 2012 through September, November and December 2012 found in R3's medical record do not identify and address behavior of R3 banging his head on the wall. There was no MONTHLY SUMMARY for October 2012. Notes for August 2012 and September 2012 document R3 uses a wheel chair intermittently. Notes for November and December document unsteady gait.

Restorative Nursing Notes of 3/30/12 document R3 has been noted consistently banging head back of occipital lobe against the dining room wall near the patio exit. Resident becomes very

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agitated and combative during this time period. Wants staff to open door to smoke during meal time. R3 refuses to eat if he does not get his way and bangs his head on the wall...Received orders to try a soft helmet to protect R3's head from injury. Note of 3/31/12 documents R3's POA (Power of Attorney) was at the facility and angry with staff stating he did not want helmet on R3. Staff attempted to explain and reason with POA. Still he refused to allow R3 to wear helmet. Refused to accept reason for safety precaution. Soft helmet removed. Received MD (Medical Doctor) order to discontinue soft helmet. There is nothing in the Restorative Nurses Notes as to what other interventions the facility would take to keep R3 safe from injury due to head banging.

Restorative Nurses Notes of 10/9/12 documents R3 is in the dining area and noted R3 attempting to bang head on wall, staff assist R3 to the table. Called POA explain once again to POA the importance of the soft helmet to be worn by R3. Explain R3 will only wear it when awake and remove it at bed time. POA decided he would allow it to be worn. Received orders for R3 to wear soft helmet when awake.

Record review of R3's Physician Orders from time of admission to discharge document there is no order for the Helmet. On 6/12/13 at 11:55AM, E13 stated she was not able to find an order for the helmet. E13 was unable to provide an invoice for the helmet purchased in March 2012 but did provide a copy of the invoice for the helmet ordered in October of 2012.

Review of the Invoice for the helmet ordered in October 2012 documents a Purchase Date of 10/9/13, a request ship date of 10/10/12, and an

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invoice date of 10/23/13. Interview with Z4, supply company representative on 6/18/13 at 10:05AM, Z4 stated the facility ordered the helmet on 10/9/12. There were none in the warehouse so the company had to order the helmet from the vendor, which is the 10/10/12 ship request date. Z4 stated the invoice date of 10/23/12 is when the helmet was shipped to the facility with overnight delivery.

The Social Service Notes document R3 was banging his head against the wall on 10/15/12. He was redirected by staff and given his helmet to wear. R3 refused to wear his helmet. He was offered a cigarette and finely complied. (The review of the invoice for the helmet documents it was shipped out on 10/23/12.)

The Social Service Note of 10/25/12 documents that R3 was banging his head on the wall. Staff attempted to redirect R3. R3 became loud and aggressive. R3 was given a cigarette to calm him down. Staff will continue to monitor and document all progress.

The Social Service Note of 10/30/12 documents R3 was observed in the dining room banging his head on the wall. R3 was redirected, but he refused to oblige. Incentives were offered and R3 obliged to wear his soft helmet and desist from banging his head on the wall.

The Social Service Note of 11/5/12 documents R3 was observed in the dining room banging his head on the wall without his soft helmet. A cigarette was offered, R3 complied, and then took off the helmet after the cigarette and threw it on the floor.

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The Social Service Note of 11/14/12 documents staff reported that R3 was hitting his head against the wall in the dining room. Notes of 11/14/12 document a contract was implemented with R3 to reduce/ will not hit his head on the wall and will receive additional goodie bag/ can of pop per day and cigarette every day behavior is not exhibited.

R3's Annual Minimum Data Set (MDS) of 12/26/12 documents that R3 is independent in transfers, walking in room, walking corridor, Locomotion on and off unit and toilet use. The MDS documents R3 is always continent of bowel and bladder. Under Section J for falls, there is documentation that R3 had two or more falls since admission/entry or reentry or since prior assessment. Injury or major injury is marked "none." Yet Monthly Summary Nurses Notes for November and December 2012 document R3 has unsteady gait and is incontinent of bowel and bladder. Report of November documents R3 wears incontinent pads and briefs.

The facility failed to do a significant change MDS for R3 and the previous MDS was done on 8/24/12. This is more than 4 months in between MDS's. During interview with E14, MDS Coordinator on 6/13/13, when asked why there was not an MDS done between 8/24/12 and 12/26/12, E14 stated, "It was missed."

R3's Comprehensive Care Plan that is dated 11/24/11, 2/24/12 and 5/24/12 documents R3 has Huntington Disease and Seizure Disorder. R3 has history of falls; impaired sense of balance and unsteady gait and generalized weakness. Care Plan Goal dated 8/12/12 documents R3 will wear protective safe soft helmet when up and about. With approach to wear protect safe soft

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helmet when up and about the facility. Check shoes for proper fit. When awake keep in common area and monitor. This conflicts with Restorative Note that the helmet was discontinued on 3/31/12. The next note addressing the use of the helmet is in Nursing Restorative Notes of 10/9/12 that documents R3 was banging his head and Z3 gave permission for the helmet and R3's helmet was ordered.

The Care Plan of 10/1/12 documents R3 exhibits physical abusive behavior towards self manifested by: bang of head on the wall related to the diagnosis of Huntington. Behavior Interventions are, "Behavior contract in place to reduce episode of banging of head on the wall." (Yet Social Service Notes document the contract was not implemented until 11/14/12.) "Intervene by speaking in a calm and professional soft tone of voice. Staff should avoid raising own voice. Offer resident cookies to distract behaviour. Staff will attempt to redirect resident from such behavior." Intervention added on 12/26/12 documents, "Staff will continue to redirect resident upon any exhibition of physical abusive behavior towards self." The first incident of head banging documented after March 2012 was documented in the Restorative Nurses Notes of 10/9/12. There is no other documentation in the medical record of head banging before this date, yet the Care Plan for R3's head banging is documented as 10/1/12 with interventions implemented on 10/1/12.

The Care Plan of 10/13/12 documents R3 had a fall related to the use of psychotropic medication and he has a diagnosis of Huntington. The Care Plan interventions include in part, order for helmet initiated 10/14/12. The Care Plan documents on

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12/30/12 to prompt R3 constantly to keep helmet on.

The Care Plan of 10/25/12 documents R3 exhibits the symptom of resisting care by refusing to put on head helmet which is related to SAD (Schizoaffective Disorder) and Huntington. The Care Plan approach is, Emphasize soothing kind, slow and compassionate speech and Try different staff members to provide care if on staff member cannot, "connect" with resident."

R3's RESIDENT CAREPLAN CONFERENCE SIGN IN SHEET of 12/28/12 document R3 was in attendance but did not have his signature. Note on the sheet documents, "R3 was reminded about the health risk of banging his head against the wall."

On 6/12/13 at 3PM, E19, Certified Nurse Aide (CNA) stated R3 wore a blue like foot ball helmet that was cushioned to protect his head when he would fall or bang his head on the wall. Sometimes R3 would take his helmet off and at times could be redirected. He would bang his head against the wall while he was in his room.

On 6/12/13 at 10:30AM, E12, CNA, stated she saw R3 banging his head in the Dining Room. He would bang his head if he was upset. He would take his helmet off. He didn't like to wear it.

During interview with E10, Social Service Director, on 6/13/13, E10 stated he is in charge of Behavior Tracking. E10 stated he implemented a Behavior Tracking System about 5 months ago. E10 stated the facility did not have a system in place for staff to documents behavior of R3 hitting

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his head and if interventions used were effective. E10 stated R3's Behaviors were documented in the Nurses Notes and Social Service Notes. E10 stated staff would go to the Social Worker and report behaviors. They determined that staff were unable to report night behaviors because no one was there to report the behaviors to. E10 stated he personally observed R3 banging his head on the wall and refuse to wear the helmet. He had aggressive behaviors. At the patio door he would stand and his his head. He did it quite often. R3 was confused about smoking time.

During interview with E13 on 6/13/13 at 9:15AM, E13, Corporate Administrator, stated the Policy and Procedure for Behavior Tracking was new for about 3 months. Prior to that behaviors were documented in the social service notes. There were no tracking forms. There was no assessment of interventions other than what was recorded in the Social Service Notes and what was on the Care Plan.

During interview with Z1, R3's Physician/Facility Medical Director on 6/12/13 at 2PM, Z1 stated he was aware that R3 was banging his head on the wall. R3 was refusing to wear the helmet. Probably because it was uncomfortable and due to his medical condition. Z1 stated he never saw R3 wearing the helmet when he visited the facility. Z1 didn't know if he had the helmet, if there was on ordering problem or if staff couldn't find it. Z1 stated, "yes, very likely indeed that banging head could contributed to subdural hematoma. Most definitely." Z1 stated he was aware of the Huntington diagnosis and didn't know what else to do for him. Z1 stated, "Probably looking back he probably didn't belong at the facility. If you are there you can see what

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type of patients they have. It's not 1 on 1 person watching." "Those people have sex all over the place. All sorts of behaviors and fighting. We can't tie them up or chemically restrain them....He would make himself fall and he would bang his head and make himself fall. Part of his diagnosis."

On 6/14/13 at 10AM, E13 stated R3's head banging was a behavior and not Huntington's. R3 maybe wanted a cigarette, thought he didn't take medication he had already taken.

The facility failed to implement Behavior Tracking and assess and monitor effectiveness of the interventions.

On 6/14/13 at 8AM, E6, Nurse for E5, (R3's Neurosurgeon), called and stated E5 stated it was reasonable to think R3 should have had a Neuro evaluation for brain trauma after the head banging on the wall began.

2. The Facility's Policy for falls/accidents dated 5/2013 documents residents will be assessed for falls on admission, readmission, any significant change, and quarterly using the falls risk assessment. For residents who have been identified as risk for falls upon admission, the plan of care shall include initial interventions to prevent injuries and accidents from falls. The Facility failed to develop a falls prevention plan that has resident oriented interventions to assist in reducing falls.

R1's MDS dated 2/20/13 identifies her to require minimal assist of one staff for transfers and all ambulation with balance deficits requiring staff

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assistance. R1's clinical record included three different Care Plans reflecting falls and additional plans for a lap buddy and ambulation. The Care Plan dated 10/21/12 identifies her as a fall risk due to unsteady gait with a goal to not sustain a fall related injury through the next review date of 7/15/13 but fails to reflect a goal to prevent falls. Review of the falls log documents that R1 is documented fell at least eight times from 11/19/12 to 5/6/13, however, the log is incomplete as it does not include falls recorded on 5/6/13, 11/21/12 and 10/21/12.

The Care Plan on admission dated 8/1/12 identifies that R1 uses a lap buddy, self release while awake and up in wheelchair. The only other interventions checked are assessing to determine the most enabling treatment, provide skin checks and care, and offer sensory and social stimulation throughout the day. The current Care Plan goal is originally dated 10/21/12, reviewed on 2/21/13 with a goal date of 7/15/14 includes only interventions that coincide with falls, the first identified on 10/21/12.

The Care Plan (10/21/12) interventions do not fall in order as they were added. There is an intervention for a low bed dated 8/12/12 with no explanation as to reason why on the Care Plan. The only intervention dated 10/21/12 when the unsteady gait is identified is to educate staff to toilet R1 every two hours and as needed when she had a fall reported. The Fall Report indicates R1 was transferred to the emergency room for treatment to a laceration above her left eyebrow. A physical therapy evaluation was ordered.

On 11/19/12, R1 is documented again as falling to the floor when the CNA stated she "slid out of

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chair." The intervention dated 11/19/12 simply documents "Staff education" but nothing resident specific on preventing further falls. On 11/21/12, R1 was again found on the floor according to a report reviewed but again, the only intervention included again is staff education.

On 12/10/12, an intervention is added to the Care Plan to "Implement fall precaution procedure" and instruct resident to ask for assistance prior to attempting to transfer or walk, place call light within easy reach and encourage use. The incident report dated 12/10/12 indicates that R1 fell into the bathtub.

On 2/11/13, the incident report/log documents that R1 attempted to get out of chair by herself and fell to the floor. Care Plan interventions indicate a lab buddy was placed on R1 along with reminding resident to call for assistance.

R1 was again reported to fall on 2/15/13 according to incident reports. The Care plan intervention dated 2/15/13 document "Staff, CNA to be inserviced" only. The Report documents that the CNA assisted the resident to the toilet and turned away from her giving the resident the opportunity to fall into the tub sustaining redness and a small abrasion on her back. E21, CNA, was inserviced on 2/18/13 to gather supplies before taking resident to the toilet.

On 4/3/13, a report indicates a housekeeper witnessed R1 falling to the floor on her buttocks but getting up herself. The only intervention added was to "encourage resident to relax during care" however, there no indication as to how this intervention is appropriate to the fall witnessed by the housekeeper.

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F9999	Continued From page 97 On 4/15/13, a report documents R1 was "walking down hallway and fell on her back." The fall was unwitnessed. The facility report documents R1 noted on the "facility camera coming out of her room initially holding on to the handrail then lost her balance and fell to the floor." An intervention to place R1 on the "falling star" program was implemented. The facility provided no explanation as to why R1 wouldn't have already been placed on the falling star program given her repeated falls prior to this date. A report dated 4/25/13 documents R1 falling after taking off her lap buddy. Training was provided to two staff, E12, CNA, and E22, Security staff, as they observed R1 taking it off and sliding to the floor with no intervention provided to prevent her from hitting the floor. On 6/12/13 at 9am, Z2, family member of R1, stated R1 has had a lot of falls lately and has declined in ambulation to where R1 in now using a wheelchair. There is no evidence that adequate supervision was provided when R1 attempted to ambulate by herself or get up by herself. (B)	F9999		