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W 441	Continued From page 77 who utilize a wheelchair for mobility. Review of the evacuation drills from 7/ 2012 to 8/ 201313, the residents and staff are participating in a full evacuation 1 time a year on each of the three shifts. There was no reproducible evidence that the residents are participating in evacuation drills under varied conditions/times throughout the year on all 3 shifts. Review of the facility's evacuation drills: Under Types of Drills. The form is marked a Verbal Drill. Per interview with E1 (Administrator) on 8/6/13 at 3:45 PM, E1 stated that verbal is defined as; The staff are verbally trained throughout the year on the evacuation drills. The verbal training is completed on all 3 shifts. There was no evidence that both staff and individuals are being trained physically by practicing the evacuation drills under varied conditions.	W 441		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.700a) 350.1210 350.1230b)7) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the	W9999		

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facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

Section 350.700 Incidents and Accidents

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

Section 350.1210 Health Services

The facility shall provide all services necessary to maintain each resident in good physical health.

Section 350.1230 Nursing Services

b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in:

7) Modification of the resident care plan, in terms of the resident's daily needs, as needed.

Section 350.3240 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)

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W9999	Continued From page 79 These requirements are not met as evidenced by: Based on record review and interview nursing failed to provide adequate assessment and monitoring of pulmonary status and implement the facilities Choking Policy for 3 of 3 individuals who choked (R9, R16 and R17). Findings Include: 1. Facility's policy titled, "How to Handle a Resident Choking issue" (dated 9/2/11) states; The following steps must take place when an incident occurs related to a resident choking on food: 1. When a resident is observed having a choking incident staff must intervene immediately to provide needed assistance/ interventions. 2. Staff must notify the nurse ASAP (as soon as possible) for assistance. 3. Nurse must come to the resident ASAP to assess immediate needs. 4. The DON (Director of Nursing) and (a) Administrator must be called and given briefing on the incident. 5. The resident must be sent to the hospital for a follow-up evaluation. 6. The nurse must complete all necessary paper work to document all that took place. 7. DSP (Direct Support Person) staff must document their involvement in the incident. 8. Once (a) resident returns from the hospital, close monitoring is to occur for the next 24 hours and document any problems.	W9999		

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W9999	Continued From page 80 9. Progressive corrective action will occur if staff fails to follow these procedures. Physician's Orders/ POS (dated 7/26/13) identifies R9 as a 53 year old individual who functions at the Profound range of Intellectual Disability and has a physician prescribed pureed diet. Resident Medical Incident Report (dated 6/18/13) states, "Called in dining room per DSP (direct Support Person) et (and) observed resident coughing. Reported that R9 reached and grabbed piece of sausage from another tray. Assessed in nurses station (and) check over resident trachea unable to hear any foreign objects at present time. Resident brought up from mouth thick white sputum copious amount. Sent to wing (and) placed on 15 minute usual per administrator." The report has an area that is titled, "witnesses to incident" which has no documentation written. In review of Nursing Notes (dated 6/18/13) and Resident Medical Incident Report (dated 6/18/13) there was no evidence that nursing thoroughly assessed R9's pulmonary status by auscultating lung sounds. There was no evidence that R9 was sent to Emergency Room for a follow up evaluation or that the DSP documented their involvement in the incident as stated per facility's policy. In review of R9's record there is no written documentation that identifies who the staff was that witnessed R9 grabbing the sausage and coughing . There is also no evidence of a statement by the direct care staff who witnessed R9 grab the food and coughing.	W9999		

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Physician's Orders (dated 6/13/13) identifies R16 as a 27 year old individual who functions at the severe range of intellectual disability with additional diagnoses of Down's Syndrome and Oropharyngeal Dysphasia. The POS states R16 has prescribed a Pureed diet with nectar thick liquids.

Behavior Intervention Plan (dated 7/17/13) states R16 is currently on Same Room Supervision that requires staff to be present in the room that R17 is in, excluding bedroom.

Resident Medical Incident Report regarding R16 (dated 5/13/13 at 15:50 PM) states, "DSP (Direct Support Person) informed nurse (writer/ E6/Licensed Practical Nurse) that (resident) took other (resident) food and ate bread- that (resident) started choking- (writer witnessed coughing emesis and spitting in bathroom of 400 wing." The report states E7/ Direct Care Staff was a witness to the incident.

Medical Incident Report (dated 5/13/13 at 6:00 PM and completed by E8/ Shift Supervisor) states, " R16 was coughing in dining room and when he return to wing E7 called nurse cause he was coughing up the bread." (typed as written)

In review of Nurse's Notes 5/13/13- 5/20/13, there are the following entries related to the choking incident of 5/13/13:

5/13/13 1750 (5:50 PM) 400 wing DSP reported to nurse (writer/ E6) that (resident) had taken a bite and ate bread at dinner (someone else's food) (resident) was brought to restroom when minor choking occurred, had a small emesis and spit a few times. Nurse (writer) assessed

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(resident) during this time.

5/13/13 2000 (8:00 PM) Assessed (resident) at this time for coughing, (choking) at this time, airway passage clear, will (continue) to monitor."

There was no evidence that nursing provided thorough assessment of R16's pulmonary status by auscultating his lungs, obtained vital signs, sent R16 to the hospital for a follow- up evaluation or that nursing continued to monitor R16's respiratory status for 24 hours as stated by facility's policy.

In review of R16's record there was no written statement by E7 regarding the "choking" incident that occurred.

In an interview with E6/ LPN on 8/9/13 at 2:50 PM, E6 stated, "I witnessed him coughing big chunks of bread on the wing." E6 confirmed that vitals should be checked and that she did not have evidence of vitals being checked. When asked when an individual would be sent to the hospital, E6 stated, "If coughing, choking or emesis persists." E6 stated that she checked on R16 again at the 8:00 PM medication pass.

Physician's Orders (dated 6/1/13- 6/30/13) identifies R17 as a 64 year old individual who has an intellectual disability and has prescribed a regular diet.

Medical Incident Report regarding R17 (dated 7/9/13 at 5:45 PM) states, "Eating (too) fast while in (dining) room. Able to bring up on own." The report has a section titled, "Witnesses to incident" which has no documentation written.

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In review of R17's record there was no written documentation that identifies who the staff was that witnessed R17 "bringing up food on own." There is also no evidence of a statement by the direct care staff who witnessed R17 during this incident.

Nurse's Notes (dated 7/10/13- 7/18/13) has the following the following entries regarding R17's incident of 7/9/13:

7/9/13 1745 (5:45 PM) "Patient got choked in the (dining room) this shift. Not chewing food up. Was able to bring up on own."

In review of Nurse's Notes and Medical Incident Report there was no evidence that nursing auscultated R17's lung to thoroughly assess pulmonary status, that R17 was sent to the hospital for a follow-up assessment, that nursing closely monitored R17 for 24 hours or that the DON or Administrator were notified of the "choking" incident.

In an interview with E1/ Administrator on 8/9/13 at 2:40 PM, E1 confirmed that R9, R16 and R17 did not go to the hospital for a follow-up evaluation as stated in the facility's policy. E1 stated, "It's old. (related to the current choking policy.) We look at choking incidents and if no issues after ten minutes will do 15 minute checks to ensure no further issues. Not always sent to the hospital." E1 confirmed that he did not have reproducible evidence of 15 minute checks for R16 or R17.

In an interview on 8/13/13 at 11:23 Am with E3/ Director of Nursing, when asked what nursing are expected to do after an individual has a choking incident, E3 stated, "Should do an assessment of

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W9999	Continued From page 84 lung sounds, call the doctor and the guardian and start the choking observation Q (every) fifteen minutes." (B) 300.620a) 350.700a)b)c) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.700 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the	W9999		

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W9999	Continued From page 85 Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 350.3240 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 thoroughly investigate 1 of 1 (R18) allegation of peer being pulled out of chair to floor by peer, 3 of 3 incidents of choking (R9, R16 and R17) and 1 of 1 (R17) injury of unknown origin of 5 or 6 small circular bruises to the left upper arm. Findings Include: 1. Individual Program Plan/ IPP (dated 7/24/13) identifies R18 as a 70 year old individual who functions at the Profound level of Intellectual Disability and utilizes a wheel chair for distance. The IPP also states R18 can walk with the use of a walker. The IPP does not identify that R18 has any behaviors that requires programming. Resident Medical Incident Report (dated 6/10/13) states, "Staff reported he heard the alarm from R18's chair and went to the TV (television) room to find R18 on the floor. Another resident told staff R16 pulled him from his wheel chair to the floor and he, R35, said R16 "did it."	W9999		

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W9999	Continued From page 86 Physician's Orders (dated 6/13/13) identifies R16 as a 27 year old individual who functions at the severe range of intellectual disability. Behavior Intervention Plan (dated 7/17/13) states R16 is currently on Same Room Supervision that requires staff to be present in the room that R16 is in, excluding the bedroom. The plan states, "To prevent or minimize aggression staff should ....keep other men and especially wheelchairs away from R16's (recliner) chair. He does not like to be crowded. When he is crowded, he has shown signs of being anxious in the past and a history of being aggressive when he is crowded by other men when (in) his chair." ABC Behavioral Incident Reporting Form (dated 6/10/13 at 7:00 AM) completed by E13/ Direct Support Person, states, " I the writer was in sub station (with) staff members shaving (R36) when alarm sounded off. Went to see what happen (sic). R18 was on floor. Asked R35 what happened he said R16 did it. Called (E1/ Administrator) was told to have R18 seen by nursing. There is no evidence presented by the facility that a thorough investigation was completed to ensure this peer to peer abuse was the result of neglect by the facility staff. 2. Physician's Orders/ POS (dated 7/26/13) identifies R9 as a 53 year old individual who functions at the Profound range of Intellectual Disability and has a prescribed pureed diet. Resident Medical Incident Report (dated 6/18/13) states, "Called in dining room per DSP (direct Support Person) et (and) observed resident coughing. Reported that R9 reached and grabbed	W9999		

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piece of sausage from another tray." The report has an area that is titled, "witnesses to incident" which has no documentation written.

In review of R9's record there was no written documentation that identifies who the staff was that witnessed R9 grabbing the sausage and coughing. There is no evidence that the facility investigated the choking incident to determine if the cause of the incident was due to staff neglect.

3. Physician's Orders (dated 6/13/13) identifies R16 as a 27 year old individual who functions at the severe range of intellectual disability with additional diagnoses of Down's Syndrome and Oropharyngeal Dysphasia. The POS states R16 has prescribed a Pureed diet with nectar thick liquids.

Behavior Intervention Plan (dated 7/17/13) states R16 is currently on Same Room Supervision that requires staff to be present in the room that R16 is in, excluding the bedroom.

Resident Medical Incident Report regarding R16 (dated 5/13/13 at 15:50 PM) states, "DSP (Direct Support Person) informed nurse (writer/ E6/Licensed Practical Nurse) that (resident) took other (resident) food and ate bread- that (resident) started choking- (writer witnessed coughing emesis and spitting in bathroom of 400 wing." The report states E7/ Direct Care Staff was a witness to the incident.

Medical Incident Report (dated 5/13/13 at 6:00 PM and completed by E8/ Shift Supervisor) states, " R16 was coughing in dining room and when he return to wing E7 called nurse cause he was coughing up the bread." (typed as written)

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W9999	Continued From page 88 The facility was unable to provide reproducible evidence that the facility has thoroughly investigated this incident to ensure the incident was not the result of staff neglect. In an interview with E6/ LPN on 8/9/13 at 2:50 PM, E6 stated, "I witnessed him coughing big chunks of bread on the wing." E6 confirmed that she did not notify the Administrator of the choking incident. 4. Physician's Orders (dated 6/1/13- 6/30/13) identifies R17 as a 64 year old individual who has an intellectual disability and has been prescribed a regular diet. Medical Incident Report regarding R17 (dated 7/9/13 at 5:45 PM) states, "Eating (too) fast while in (dining) room. Able to bring up on own." The report has a section titled, "Witnesses to incident" which does not have any documentation written. In review of R17's record there was no written documentation that identifies who the staff was that witnessed R17 "bringing up food on own." There was no evidence of a statement by the direct care staff who witnessed R17 during this incident. There is no evidence that an investigation was completed to ensure safeguards are in place to prevent further choking incidents. 5. R17's Resident Medical Incident Report (dated 6/3/13 at 3:03 PM) completed by E9/ LPN states, "While assisting resident (with) shower (E15)DSP/ direct Support Staff noted a bruise to left upper arm with 5 or 6 (small) circular bruises. Unknown incident report initiated Administer	W9999		

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aware."

Medical Incident Report (dated 6/3/13 at 3:00 PM) completed by E10/ Qualified Intellectual Disability Professional states, "DSP staff (E15) reported observing apparent bruising on R17's upper (left) arm (5-6 small circles), observation made in shower while assisting (with) bathing."

In interviews with E1/ Administrator on 8/9/13 at 10:55 AM and 3:30 PM, E1 stated that he could not provide any reproducible evidence that the facility thoroughly investigated R9, R16 and R17's choking incidents, the allegation made that R16 pulled R18 from his chair onto the floor or R17's injury of unknown origin. E1 confirmed that R16 is on Same Room Supervision and should have staff in the room with him at all times excluding his bedroom. E1 stated that when an Injury of Unknown Origin is found that the Nurse will give staff "Unknown Reports" to fill out on her shift, and put extra reports in the E14/ Residential Service Director's box to pass out to staff that worked the past 24 hours prior to discovery of the unknown injury. E1 confirmed that he was unable to provide the completed statements and the results of the investigation regarding R17's unknown injury to his upper arm. E1 confirmed that Same Room supervision was not implemented for R16 prior to the time staff found R18 on the floor.

Facility's "Policy and Procedure Regarding Abuse and Neglect" (no date) identifies neglect in part as, "The failure to provide or ensure medical attention for physical injuries to a resident or residents." The policy also identifies neglect as, "Evidence of abuse or neglect, such as a pattern or trend of unexplained injuries such as cuts,

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W9999	Continued From page 90 bruises, scratches, fractures, bleeding, or burns." The policy states "(Facility) must and will have evidence that all alleged incidents of abuse and neglect are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress." (B) 350.620a) 350.1210 350.1230b)6)7) 350.1230c) 350.1230d)2) 350.1610b) 350.1610c)3) 350.1610g) 350.3240a) 300.620a)Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health.	W9999		

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W9999	Continued From page 91 Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. c) A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel. d) Direct care personnel shall be trained in, but are not limited to, the following: 2) Basic skills required to meet the health needs and problems of the residents. Section 350.1610 Resident Record Requirements b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives. c) Record entries shall meet the following requirements: 3) Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals	W9999		

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W9999	Continued From page 92 authorized to make such entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments including, but not limited to, radiologic or laboratory reports and other similar reports. g) Treatment sheets shall be maintained recording all resident care procedures ordered by each resident's attending physician. Physician ordered procedures that shall be recorded include, but are not limited to, the prevention and treatment of decubitus ulcers, weight monitoring to determine a resident's weight loss or gain, catheter/ostomy care, blood pressure monitoring, and fluid intake and output. Section 350.3240 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 he facility failed to have comprehensive policies for altered skin prevention, and failed to have evidence of thorough treatment, nursing documentation, direct care documentation for 3 of 3 individuals who obtained open areas, 1 inside the sample, (R8), and two outside the sample (R11 & R12). Findings include:	W9999		

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1. The Physicians Order Sheet (POS), dated 07/26/13, identifies R11 as an individual who functions at a Severe level of Intellectual Disabilities. R11's POS states under Treatments, "Cleanse area on coccyx daily with normal saline or wound cleaner. Apply skin barrier peri wound to help secure dressing. Apply pea sized amount of Silver Hydrogel, cover with Puracol. Cover with white bordered foam dressing."

The facility The Rounds Tool for R11's repositioning every two hours states,
08/07/13
0900-in bed, no position recorded
1300-in bed, no position recorded
2300-in bed, no position recorded
0100-in bed, no position recorded
08/08/13
0900-in bed, no position recorded
1100-in bed, no position recorded
1700-wheelchair
1900-wheelchair
2300-in bed, no position recorded
0100-in bed, no position recorded
8/09/13
0900-left side-no location recorded
1100-left side-no location recorded
1700-wheelchair
1900-wheelchair
2300-in bed, no position recorded

Per record review of R11's Nursing Notes, Treatment Record, and Weekly Pressure Sore Report, there was no evidence a thorough nursing assessment of R11's open area, nor ensure that this client is repositioned as identified in the Round Tool from 06/01/13 until 08/07/13.

During an interview with E5, Qualified Intellectual

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Disability Professional, (QIDP), on 08/07/13 at 4:40 PM, E5 confirmed that R11 did not have a special mattress or mattress covering to help promote skin integrity. There are no identified preventative skin care recommendations from nursing.

2. The Physicians Order Sheet (POS), dated 07/26/13, identifies R12 as an individual who functions at a Severe level of Intellectual Disabilities. The POS for R12 further states under diagnosis: Seizures, Constipation, and Osteoarthritis of Left Knee/Left Hip. R12's POS states under Treatments, "Cleanse area on coccyx daily with normal saline or wound cleaner. Apply skin barrier peri wound to help secure dressing. Apply pea sized amount of Silver Hydrogel, cover with Puracol. Cover with white bordered foam dressing."

A facility Memo, dated 07/0913. states:
1. R12 can bear weight and able to assist during transfer.
2. R12 has very minimal progress in using hi platform walker. R12 gets very upset when trying to make him walk.
3. R12 is transported by a wheel chair on short and long distances.
4. Staff needs to get R12 out of the wheelchair every 2 hours. R12 likes sitting on the recliner.
5. Additional continuum of care plan will be discussed during CC (Coordination of Care) or Interdisciplinary Team.

The facility The Rounds Tool for R12's repositioning every two hours states,
08/07/13
0900-in bed, no position recorded
1300-in bed, no position recorded

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W9999	Continued From page 95 2300-in bed, no position recorded 0100-in bed, no position recorded 08/08/13 0900-in bed, no position recorded 1300-wheelchair 1500-day training (wheelchair) 1700-wheelchair 1900-toilet 2300-in bed, no position recorded 0100-in bed, no position recorded 8/09/13 1500-day training (wheelchair) 1700-wheelchair 1900-wheelchair 2300-in bed, no position recorded 0100-in bed, no position recorded Per record review of R12's Nursing Notes, Treatment Record, and Weekly Pressure Sore Report, (dated 7/13/13-8/7/13) there was no evidence a thorough nursing assessment of R12's wounds with nursing recommendations for preventative skin care. During an interview with E12, Direct Staff Person (DSP), on 08/07/13 at 2:06 PM, E12 confirmed that the documentation for R11 and R12, does not confirm what position the individuals are in at any given time. The lack of this identification of individuals position does not ensure that these individuals are being repositioned every two hours. During an interview with E3, Director of Nursing (DON), on 08/08/13 at 2:55 PM, E3 stated "It would be better if R11 & R12 were repositioned every hour or 1 1/2 hour." When the surveyor asked E3 if it was appropriate to reposition R11 & R12 on their backs, E3 stated, "Prefer side to	W9999		

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W9999	Continued From page 96 side (positioning) and use equipment if needed." During an interview with E3, Director of Nursing (DON), on 08/13/13 at 11:23 am, when surveyor asked if R11 & R12 had new Physical Therapy, Occupational Therapy, or Nutritional Assessments completed due to their altered skin integrity, E3 stated "No." During an interview with E3, Director of Nursing, (DON), on 08/13/13 at 11:23 AM, the DON confirmed documentation is expected regarding wound care and treatment including measuring and assessment of the wound(s), by nursing department of open areas for R11 and R12. The facility Procedure for 'Pressure Ulcers Only', dated 07/06/11, states: 1. ...All blanks must be filled out including measurements, treatments and date identified. In addition, the nurse must fill out the information on a weekly pressure sore report that shall include the date, site, stage, size, depth, drainage, color odor and treatment.. 3. R8, per Physicians Order Sheet (POS) of 8/13, is a 57 year old male with diagnoses of Severe Spastic Paraplegia, Cerebral Palsy, and Cervical Spine Stenosis. A fax to Z1 (R8's Physician) dated 8/20/12 states "resident [R8] has open areas to rt [right] foot, 2nd, 3rd, 4 th digits 0.5 cm X 0.5 cm circular in shape." A fax to Z1 dated 8/21/12 states that R8 was seen by the "wound nurse today." The fax was asking for an order to implement the recommendations from the wound nurse. R8's Treatment Record [TR] for August 2012	W9999		

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contains an order to "Cleanse rt foot 2nd, 3rd, 4th toes daily [with antibiotic ointment] Apply skin prep [and] leave OTA [open to air] until Healed." The TR for August 2012 shows the treatment being applied from 8/22 through the end of the month. There is no evidence of the weekly evaluation by nursing regarding measurements or healing status of these wounds.

A nurses note dated 9/8/12 regarding R8 states, "Writer noted superficial abrasion app [approximately] 2 cm by 0.1 cm to [R8's] rt foot rt above toes. DSP [direct care] Supervisor stated that [R8] does a lot of rubbing of his feet when he goes to bed. Possible self inflicted."

The TR for R8 for September 2012 shows R8 receiving the treatment for the entire month except for 9/8, 9/9, 9/13, 9/17, and 9/28. No other nurses notes for 9/13 addresses the abrasion or open area and the TR for September 2012 does not contain any description or measurements regarding the injuries to R8.

The next nurses note regarding injuries to R8's right foot is 11/27/12 which states, "Has rubbed 2 sores on top of his 2nd + 3rd toes on rt foot." No size or description is included. R8's TR for 11/12 contains an entry on the back dated 11/25/12 which describes a .5 cm round superficial sore to 3rd toe on right foot. It continues "Toes 2 and 4 have sores that are starting to form." A fax to Z1 dated 11/27/12 states, R8 "has rubbed 2 sores on the top of rt foot 2nd and 3rd digit both areas are draining clear drainage and skin surrounding is inflamed." Z1 ordered an antibiotic. An entry dated 11/30/12 describes R8's injury as inflammation to 2nd and 3rd toe scabbed over.

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A fax to Z1 dated 12/04/12 states that R8 "has scabbed areas on the 2nd and 3rd digits on rt foot currently on [antibiotic] but could we get an order for TAO and bandage till healed." Z1 approved of this order. R8's TR for December 2012 shows that this order as being initiated on 12/04/12 and R8 continued to receive the treatment through the end of December 2012. The last entry in the nurses notes regarding the injury is 12/06/12. There is no evidence of the weekly evaluation by nursing regarding measurements or healing status of these wounds.

A nurses note regarding R8 dated 5/19/13 states, "Res. [resident] has reopened area to 4th digit rt foot - notified [physician] of incident." No description of the injury is included. A fax to Z1 dated 5/20/13 states, "Res (resident) has skin tear of 4th digit rt foot." Incident report dated 5/19/13 states, "Res has an open area on 4th digit that has reopened." On the back of the incident report it is listed as a "skin tear." None of the nurses notes regarding the injury to R8's right foot describe the injury or whether is has any drainage, the size of the area or level of healing. The TR for May 2013 does not contain any description of the injury. A fax to Z1 dated 5/27/13 requests an order for "TAO cover with 2 X 2 wrap with elastic wrap bandage to 3, 4 & 5 digit. Wrap for protection 3 & 5 digit have scabbed area on top and 4th digit is superficial."

The TR, for June 2013 which shows R8 receiving treatment from 6/02/13 throughout 6/28/13, does not contain any weekly evaluation of the wound or how the injury is resolving.

E3 (DON/ Director of Nursing) was interviewed on 8/07/13 at 2:55 PM. When asked why R8's toes

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continue to open, E3 stated, "I'm thinking it had to do with his shoes." When asked if a plan was developed to prevent R8's injuries from reoccurring, E3 stated, "No, care plans are up to the Q's (QIDP/ Qualified Intellectual Professional)." At 3:20 PM., E3 stated that E9 (evening nurse) stated that R8 rubs his feet constantly at night and has done it for years. E3 stated, "We need to look at boots."

E10 (Qualified Intellectual Disability Professional, QIDP) was interviewed on 8/09/13 at 1:30pm. When asked if the QIDP's are responsible for developing prevention plans for open areas, E10 stated, "No, nursing."

E3/DON was interviewed on 8/13/13 at 10:25 am. When asked who was responsible for a prevention plan for R8's open areas, E3 stated that if there is a problem they hold a meeting, try to find out what the problem is and what to do. E3 stated that the QIDP's write it up in the Individual Program Plan (IPP). When asked if a nursing care wound prevention plan was developed for R8 after the open area in 8/12, E3 stated that he had "protectors" but that he refused to wear them. E3 was asked if there was any prevention plans developed after the areas on R8's foot opened again in 11/12 and 5/13. E3 stated that the order on 5/27/13 was to wrap to protect. When asked if the wrap order of 5/27/13, meant R8 should not have the areas open to air, E3 stated, "Correct." When asked again if there was a plan to prevent the injuries from reoccurring, E3 stated, "No, it wasn't until last week." E3 was referring to the protective boots provided to R8 last week which were "thicker." E3 stated that R8 had protectors but that the ones she provided last week were thicker and

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W9999	Continued From page 100 covered more of the foot. E3 stated that he refused to wear those also. E3 was unable to provide evidence of any specific plans the facility put in place after any of the incidents of the wounds for R8 to prevent further occurrence, other than providing foot protectors which had not proven effective. R8's Individual Program Plan of 4/25/13, under the section titled "Supports and Services" contains a "Repositioning schedule - to relieve pressure related to spastic paraplegia (repositions self at night)." It also identifies a "Pillow - between ankles at bedtime to relieve pressure from leg scissoring." It does not address the use of "Protectors" or address prevention of the reoccurring sores on R8's right foot. During an interview with E3, Director of Nursing, (DON), on 08/13/13 at 4:50 PM, E3 confirmed the only policy/procedure for altered skin prevention was Preventive Skin Care. E3 confirmed that this policy does not include all areas of interventions that would be expected for the healing process including dietary, physical therapy or occupational therapy assessments. (B) 350.1210 350.1230b)7) 350.1420a) 350.3220f)	W9999		

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W9999	Continued From page 101 350.3240a) Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. Section 350.1420 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 350.1610. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered by the licensed prescriber and at the designated time. Section 350.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee	W9999		

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W9999	Continued From page 102 within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) Section 350.3240 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 assessment and monitoring of pulmonary status to ensure individuals are provided with prompt medical treatment for R14 and R15 who developed Pneumonia. Findings include: 1. Physician's Orders/ POS (dated 8/1/13-8/31/13) identifies R14 as a 63 year old individual who functions at the Moderate range of Intellectual Disability with additional diagnoses of Downs Syndrome. The POS states R14 has prescribed a Pureed Diet with honey thick liquids. The POS also states, "Monitor for signs/ symptoms of aspiration" and "Universal Aspiration Precautions." The POS states R14 has prescribed "Proair two puffs twice a day as needed" with a start date of 6/20/13. In review of R14's Nurse's Notes (dated 7/14/13-7/29/13) the following entries were noted regarding assessments and monitoring of R14's respiratory status:	W9999		

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7/18/13 6:30 AM- Resident noted to have congestion (with) lung sounds when coughing noted. Can we have an order from biotech X ray (and) faxed to Z1/ Physician (and) awaiting response.

There is no further evidence of nursing assessing this individual's respiratory status or following up on the 7/18/13 request for an X ray related to chest congestion from the physician..

Medical Incident Report (dated 7/30/13 at 10:20 AM) completed by E10/ Qualified Intellectual Disability Professional states, "Took R14 to nurse to report productive cough and congestion. Phlegm observed on lap blanket, presumably coughed up by R14. (coughing heard but not directly observed. Raspy breathing after coughing incident)." The report further states, "Nurse took note of issues and stated that doctor would be notified." There is no evidence that the nurse evaluated this individual's lung sounds or vital signs.

In review of R14's Nurse's Notes (dated 7/30/13-8/11/13) the following entries were noted regarding assessments and monitoring of R14's respiratory status:

7/30/13 12:40 PM-" faxed Z1 in (regards) congestion (and) some regurgitation during meals. "There was no documentation of a thorough assessment of R14's respiratory status including auscultation of lung sounds and vital signs.

7/30/13 8:43 PM- " 97.7 No reply back from Z1. (No) regurgitation reported during meal."

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W9999	Continued From page 104 8/1/13 4:30 PM- "Upper congestion noted. Afebrile." 8/2/13 6:00 AM- T (temperature) 96.9. Rested all night. No congestion noted." 8/11/13 12:50 PM- Resident coughed and had emesis (times) two of undigested food. Incident happened during lunch time. Resident was cleansed (and brought to nurse's station.) (vital signs) T 97.5 axillary, (blood pressure) 105/66, (pulse) 65 (respirations) 16. Lungs auscultated. Abnormal lung sounds heard in (left anterior upper lobe and (bilateral) posterior upper lobes. Z1 was paged awaiting call back. 8/11/13 1:20 PM- Nurse returned call to (clinic) to obtain an order for resident. Z1 called at home. Nurse informed (Z1) of (R14's) condition . Order was given for chest X ray. In summary on 8/11/13 the X-ray was taken at the facility and Z1 prescribed Levaquin, Albuterol Nebulizer Treatments and Oxygen to be kept at above 90 percent for Pneumonia. In review of the nursing notes, nursing did not provide thorough assessments or monitoring of R14's respiratory status from 7/30/13 - 8/11/13. Nursing also did not follow up to the request of a chest X-ray made on 7/18/13, as it was not completed as ordered by the physician. In review of Medication Administration Record for 7/1/13- 8/13/13, the PRN (as needed) Proair had not been documented to have been administered to R14, as ordered by the physician. In an interview with E3/ Director of Nursing on 8/13/13, E3 confirmed that no X ray had been	W9999		

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taken related to the request made by nursing on 7/18/13 and that nursing did not follow up on the request. E3 confirmed that nursing did not provided monitoring , thorough assessments and follow up regarding R14's respiratory status.

2. Physician's Orders/ POS (dated 6/14/13-7/13/13) identifies R15 as a 56 year old individual who has prescribed a Pureed diet with spoon thickened liquids. The POS further states R15 is at risk for aspiration.

Individualized Program Plan (dated 4/25/13) states R15 is fed by staff.

In review of Nurse's Notes (dated 6/5/13-6/10/13) the following entries were made regarding nursing assessing R15's pulmonary status:

6/5/13 10:00 AM-" R15 has had (hiccups) since 0700. Staff thought they heard some congestion when he first (got) up Writer attempted to listen to lung sounds heard nothing unusual except for the (hiccups). Temp 99.5. DON (Director Of Nursing) stated to fax Z1 for Thorazine 25 mg (every 8 hours PRN for (hiccups)."

6/8/13 10:35 PM- (No signs or symptoms) of respiratory distress.

6/10.13 2:00 PM- "Staff reported R15 has not had output this shift. Writer heard (rhonchi) in (right upper) lobe. Faxed Z1 for possible orders."

6/10/13 19:40 PM- (vital signs BP 79/46, (pulse) 61 (respirations) 16 (temperature) 99.8 SPO2 (Specific oxygenation) 95 %. .....hard to wake up. Very lethargic when opens eyes. (no) urinating on

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W9999	Continued From page 106 shift to this time. (resident has a mouthful of yellowish frothy liquid and spitting up. Per Z1 send to ER (emergency room) for evaluation. 6/11/13 - (resident) admitted for Pneumonia. In review of Nurse's Notes, nursing did not complete thorough assessments and monitoring of R15's pulmonary status inclusive of auscultating lung sounds and obtaining full vital signs. Nursing documented R15 as having episodes of hiccups on 6/6/13 at 11:10 AM, 6/6/13 at 7:30 PM, all night on 6/7/13- 6/8/13 night shift., 6/8/13 evening shift into night shift and day shift on 6/10/13. Nursing documented temperatures taken as follows: 6/6/13@ 8:00 PM= 97.8, 6/7/13 @ 00:45 AM= 98.6 and 6/8/13 @ 12:00= 98.0. In an interview with E3/ Director of Nursing on 8/13/13, E3 confirmed that documentation of nursing assessments would be found in the nursing notes and that the facility could provide no additional evidence of nursing providing monitoring , thorough assessments and follow up regarding R15's respiratory status (B) 350.620a) 350.1410a) 350.1420a) 350.1430a) 350.3240a)	W9999		

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W9999	Continued From page 107 Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1410 Medication Policies and Procedures a) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. Medication policies and procedures shall be developed with the advice of a pharmaceutical advisory committee that includes at least one licensed pharmacist, one physician, the administrator and the director of nursing. This committee shall meet at least quarterly. Section 350.1420 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 350.1610. All such	W9999		

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W9999	Continued From page 108 orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered by the licensed prescriber and at the designated time. Section 350.1430 Administration of Medication a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents. Section 350.3240 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 develop and implement a policy regarding medication administration that identifies: a. Only qualified licensed staff are to administer medications. b. Medications are to be administered as prescribed by Physician's Order. c. Medications are transcribed correctly. d. Nursing staff are to state rationale for giving as	W9999		

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W9999	Continued From page 109 needed medications. e. All medications are available for administration. This affects, or has the potential to affect R1-R96. Findings include: 1. The Physician's Orders Sheet (POS), dated 06/27/13, identifies R4 as an individual who functions at a Severe level of Intellectual Disabilities. The POS for R4 states R4 has diagnosis of Tinea Pedis, Allergies, and Hypothyroidism. R4's physician's orders does not include Seizures or Epilepsy. R4's medication list does not include the medication Dilantin, which is used for seizures. A Medication Error Report, dated 05/01/13 at 5:20 PM, states "R4 was accidently given another pts (patients) meds by E4/ Qualified Intellectual Disability Professional/ QIDP." 'Medication Error Report further states under the Medication Involved was Dilantin 200 mg (milligram). During an interview with E4/ Qualified Intellectual Disabilities Professional, on 08/09/13 at 3:40 PM, E4 confirmed that he had the medication and gave the medication to the wrong person. E4 stated he could not remember which nurse gave him the medication to administer while on an outing with R4. E4 confirmed that he is not a licensed nurse professional to legally administer medications. During an interview with E3, Director of Nursing (DON), on 08/07/13 at 3:46 PM, E3 stated that E1 gave approval for E4, Qualified Intellectual Disabilities Professional (QIDP) to administer medications to R49 while on an outing to a ball	W9999		

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game. E3 confirmed E4 administered medications incorrectly to R4.

During an interview with E1, Administrator, on 08/07/13 at 5:03 PM, E1 confirmed he was aware of the medication error that occurred on 5/1/13, in which E4 gave a medication to the wrong individual/ R4. E1 confirmed that a nurse was not sent on the outing to the ball game, and he gave approval for nursing to package the medication and give E4 the medication to administer. E1 further confirmed that E4, QIDP, is not a licensed nurse professional and that E4 can not legally administer medications to individuals who reside at the facility. E1 additionally confirmed that the Director of Nursing (DON) was aware of the plans to have E4/ QIDP to administer the medications prior to the outing.

2. The Physician's Orders Sheet (POS), dated 06/06/13, identifies R13 as an individual who functions at a Moderate level of Intellectual Disabilities. The POS for R13 states R13's diagnosis includes Diabetes Mellitus. R13's POS further states Glucagon Kit 10 MG (milligram) as directed (for low blood sugar readings).

The Resident Medical Incident report, dated 05/03/13, at 12:00 AM, states "...blood glucose reading 47...No Glucose Injection available..." The report states the facility called 911 and sent R13 to (local hospital.)

The 'Accucheck Monitoring Sheet' for R13 states on 05/03/13 at 12:00 AM, R13's accu check (blood sugar monitoring) was 47, and then 41.

During an interview with E3, Director of Nursing

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W9999	Continued From page 111 (DON), on 08/15/13 at 8:24 am, E3 states all medications are expected to be available to administer when needed. 3. R2, per Physician's Order Sheet (POS) of 5/13 is a 67 year old male. R2's POS of 5/13 contains a treatment order for Debrox 6.5% solution Instill 4 drops into both ears once daily for 3 days then on the 4th day irrigate as needed. R2's Treatment Record (TR) for May, 2013 contains initials indicating that R2 had the Debrox drops instilled on 5/11. The boxes for 5/12, 5/13 and 5/14 are not filled in. On 5/15 it is hand written in irrigate. There is no entry on the back of the TR as to why the Debrox was used, if the Debrox used as ordered on the other days, or the results of the irrigation. E3 (DON) was interviewed on 5/13/13 at 10:15 am. When asked if the Debrox was given on the other three days as per order, E3 stated, "I'm gonna have to say no since it's not documented." 4. R20's Physician's Orders (dated 6/10/13) states, "D/C (discontinue) Vimpat." R20's Medication Administration Record (dated 6/1/13-6/30/13) has lines marked through and D'cd (discontinued) with date of 6/10/13 handwritten across the Vimpat tab 150 mg. R20's Nurse's Notes has an entry dated 6/12/13 which states, "Vimpat given by accident was (discontinued) on the 6/10/13." Medication Error Report (dated 6/12/13) states R20 was given Vimpat 150 mg on 6/12/13 (no	W9999		

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time stated) which had been discontinued on 6/10/13. The report states that the discontinued card (medications) had not been pulled from the (medication) cart after it had been discontinued and that E9/ Licensed Practical Nurse did not follow the Medication Administration Record when administering the medication.

5. Per Physician's Orders/ POS (dated 7/26/13) R8 had a change in his Multivitamin to a Multivitamin with Minerals on 5/27/13. In review of R8's Medication Administration Records/ MARS, R8 had medication administration errors related to the Multivitamin and Mmultivitamin with Minerals from 06/01/13 -8/7/13.

Per POS (dated 6/6/13) and Medication Incident Report (dated 5/3/13), R13 did not receive his prescribed Glucagon 10 mg injection as ordered.

Per POS (dated May 2013) and Treatment Record (dated May 2013), there is no written evidence that R2 received his Debrox drops on 5/12/13 and 5/13/13 or that his ears where irrigated on 5/14/13 as ordered.

Per POS (dated 6/10/13) and MARS (dated 6/1/13- 6/30/13), R20's Vimpat had been administered on 6/12/13 which had been discontinued on 6/10/13 .

In an interview with E3/ DON (Director of Nursing) on 8/7/13 at 3:15 PM, E3 confirmed the facility does not have a policy/ procedure regarding medication errors.

During an interview with E1, Administrator, confirmed in an interview on 08/07/13 at 5:03 PM,

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W9999	Continued From page 113 the facility does not have a policy/procedure for medication errors. (B) 350.620a) 350.1230c) 350.1230d)2) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1230 Nursing Services c) A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel. d) Direct care personnel shall be trained in, but are not limited to, the following: 2) Basic skills required to meet the health needs and problems of the residents. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or	W9999		

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W9999	Continued From page 114 agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are nto met as evidenced by: Based on observation,record review and interview the facility failed to ensure direct care staff were trained to perform their duties efficiently & competently when the facility failed to ensure: 1. Nursing staff who administered a discontinued medication to 1 of 1 individual (R20) received training on administering medications utilizing the Medication Administration Record. 2. Direct Care Staff received training to ensure Same Room Supervision is implemented for 1 of 1 individual (R16) who pulled a peer from his wheelchair onto the floor. 3. Nursing Staff and Direct Care staff received training on the Vagal Nerve Stimulator (VNS) utilized by 1 of 1 individual in the sample (R9) who has seizures. Findings Include: 1. R20's Physician's Orders (dated 6/10/13) states, "D/C (discontinue) Vimpat." R20's Medication Administration Record (dated 6/1/13-6/30/13) has lines marked through and D'cd (discontinue) with date of 6/10/13 handwritten across the Vimpat tab 150 mg. R20's Nurse's Notes has an entry dated 6/12/13 which states, "Vimpat given by accident was (discontinued) on the 6/10/13."	W9999		

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W9999	Continued From page 115 Medication Error Report (dated 6/12/13) states R20 was given Vimpat 150 mg on 6/12/13 (no time stated) which had been discontinued on 6/10/13. The report states that the discontinued card (medications) had not been pulled from the (medication) cart after it had been discontinued and that E9/ Licensed Practical Nurse did not follow the Medication Administration Record when administering the medication. In an interview with E3/ Director of Nursing on 8/14/13 at 8:45 AM, E3 confirmed the medication error for R20. E3 stated, "The discontinued medication card was still in the cart and E9/ Licensed Practical Nurse gave it." When asked if nursing are to utilize the MARS (Medication Administration Record) when administering medications, E3 stated "They should follow the MARS, not go by the med cards." E3 stated that the person who takes off the discontinued medication order is to pull the medication card out of the medication cart."E3 confirmed that there is not a medication policy and that she could not provide any reproducible evidence that staff had been retrained on medication administration utilizing the MARS. 2. Physician's Orders (dated 6/13/13) identifies R16 as a 27 year old individual who functions at the severe range of intellectual disability. Behavior Intervention Plan (dated 7/17/13) states R16 is currently on Same Room Supervision that requires staff to be present in the room that R16 is in, excluding the bedroom. The plan states, "To prevent or minimize aggression staff should ....keep other men and especially wheelchairs away from R16's (recliner) chair. He does not like	W9999		

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to be crowded. When he is crowded, he has shown signs of being anxious in the past and a history of being aggressive when he is crowded by other men when (in) his chair."

Resident Medical Incident Report (dated 6/10/13) states, "Staff reported he heard the alarm from R18's chair and went to the TV (television) room to find R18 on the floor. Another resident told staff R16 pulled him from his wheel hair to the floor and he , R35, said R16 "did it."

ABC Behavioral Incident Reporting Form (dated 6/10/13 at 7:00 AM) completed by E13/ Direct Support Person, states, " I the writer was in sub station (with) staff members shaving (R36) when alarm sounded off. Went to see what happen (sic). R18 was on floor. Asked R35 what happened he said R16 did it. Called (E1/ Administrator) was told to have R18 seen by nursing."

In interviews with E1/ Administrator on 8/9/13 at 10:55 AM and 3:30 PM, E1 confirmed that R16 is on Same Room Supervision and should have staff in the room with him at all times excluding his bedroom. E1 confirmed that Same Room supervision was not implemented for R16 during the time of R18 being pulled from his wheel chair. E1 confirmed that he could not provide reproducible evidence that the staff that failed to provide the Same Room Supervision were retrained to ensure competency in their job.

3. The Physicians Order Sheet (POS), dated 07/26/13, identifies R9 as an individual who has

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W9999	Continued From page 117 prescribed a Vagal Nerve Stimulator for seizures which state, "Nerve Stimulator, Keep magnet on wrist - if seizures, swipe magnet." During an interview with E3, Director of Nursing, (DON), on 08/13/13 at 11:23 AM, the DON confirmed the facility does not have a policy for the Vagal Nerve Stimulator. (B)	W9999		