STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145947	A. BUILDING _____ B. WING _____	09/21/2010

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PLAZA NURSING AND REHAB CTR	3249 WEST 147TH STREET MIDLOTHIAN, IL 60445

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F 000	INITIAL COMMENTS Annual Licensure and Certification Federal Oversight Support Survey(FOSS) Complaint Investigation(s): 1093144/ IL48874 - F309 1092331/ IL47912 - F406 "Licensure Survey For Sub Part S: SMI". An extended survey was conducted.	F 000		
F 164	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of	F 164		10/15/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 164	Continued From page 1 the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure privacy for one resident outside the sample (R25) by not removing him from public view during medication administration. Findings include: On 9/7/10 between 4:45pm and 5:30pm, during the medication pass observation surveyor observed E4 (nurse). During this observation, E4 administered Novolin R, 6 units to R25, in the lower right abdomen. This took place in R25's room at his bedside (bed 1). Prior to administering insulin to R25, E4 did not pull the privacy curtain or close the door. R25 was in full view of anyone passing by during this time.	F 164		
F 167	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.	F 167		10/15/10

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F 167	Continued From page 2	F 167		

This REQUIREMENT is not met as evidenced by:
Based on observation and interview on 9/08/2010 the facility failed to have available for all 80 residents and family members, the last survey results and a posting in a highly visible area, directly residents to the location of the survey result. In addition, on 9/09/2010 the facility failed to have available, the most recent survey conducted by the state agency with the accompanying plan of correction.

Findings include:

On 9/08/2010 the surveyor conducted an envirnomental tour of the facility's two nursing units. During the time of the tour, the surveyor did not observed any posting directing residents to the location of the survey results. At 11am, the surveyor asked E15 (certified nurse aide) where was the survey results located. E15 walked down to the end of the Unit 1, and pointed to a empty container attached to the wall. E15 stated, this is where it should be. E16 came in the reception area where both the surveyor and E15(restorative aide), began searching for the survey book. E15 asked, E16 if she knew where the survey book was located. E16 pointed to the empty container attached to the wall on Unit 1.

On 9/09/2010 at 9:30am, the surveyor noted a black binder labeled with words "survey results." The surveyor retrieve this binder and noted an annual survey dated 10/30/2009. The survey results had no accompanied plan of correction for

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F 167	Continued From page 3 the deficiencies written.	F 167		
F 221	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure 1 of 16 sampled residents (R12) is free of any type of physical restraint, which is not being used to treat a medical symptom. On 9/07 and 9/08/2010, R12 was positioned in a geriatric chair in the lowest reclining position. This prohibited R12 from rising or sitting up in a 90 degree sitting position, while in the chair. Findings include: On 9/07/2010 at 4:35pm, R12 was positioned in a geriatric chair in the Unit 2 television viewing area. R12 was placed in the lowest reclining position of the chair. E19 (certified nurse aide) who was in the area at the time, told the surveyor R12 was in the chair like that, because he tries to get up. On 9/09/2010 at 10:46am, the surveyor observed R12 in the Unit 2's television viewing area, in the geriatric chair. R12 was making several attempts to sit up in the chair. R12 told the surveyor he wanted to sit up.	F 221		10/15/10

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F 221	Continued From page 4 At 12:40pm, the surveyor interviewed Z4 (family member) regarding R12's customary preferences. According to Z4, R12 is motivated to be more independent after is stroke. R12 came from another nursing home, where he was up in a wheelchair and that made him more independent. Z4 stated, she requested a wheelchair for R12 but he had not got it yet. The surveyor reviewed R12's medical record and initial minimum data set (MDS) assessment for the use of the geriatric chair. No indication for the use of the geriatric chair was found. R12's care plan dated 8/02/2010 does not address the use or purpose of the geriatric chair or a restraint usage. On 9/09/2010 at 5:15pm, during the daily status meeting the surveyor informed the administrative staff, including E1 (administrator) and E2 (director of nurse), of the above information and requested an restraint assessment for R12. On 9/12/2010 the administrative staff did not present the requested information.	F 221		
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225		10/15/10

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F 225	Continued From page 5 The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to thoroughly investigate and report the unknown and unwitnessed injury of 1 of 16 sampled residents (R6). Findings include: On 9/07, 9/08, 9/09/2010 and 9/13/2010, the surveyor observed R6 ambulating outside the facility the morning (10-11am) and afternoon (3-4pm) periods. R6 was not in any staff visible	F 225		

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F 225	Continued From page 6 monitoring at the time. R6 had an incident report dated 6/09/2010, indicating R6 was noted to have a bruise to the right jaw area. It was red in color resident stated the he slept with his fist balled up under his cheek while he was asleep. The post accident/incident report dated 6/09/2010 with a time of 12:11pm, states R6 was outside prior to the accident/incident. The nurse's computerized documentation at 12:11pm, noted this information and it was an unwitnessed event. The investigation did not go beyond the statement of R6. There was no nurse's assessment to determine if it was an actual bruise or a non-blanchable area (redness cause by pressure between two surfaces). The facility had no documented evidenced this unknown/ unwitnessed injury was reported to the state agency at the time. The surveyor found the incident among the facility's non-reportable incidents.	F 225		
F 226	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based review of the abuse investigation, interview and abuse prevention program policy, the facility failed to:	F 226		10/15/10

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F 226	Continued From page 7 1. to follow their abuse policy and procedure on reporting within preliminary 24 hour any allegation of abuse to the state agency. 2. reported 4 staff employee (E6, E7, E8 and E9) who was involved in allegation of abuse. 3. provided a completed abuse investigation with date, time, location and circumstance of the alleged incident. Finding Includes: 1. Review of the final abuse investigation on 01/28/10 denoted at approximately 4:00 pm on Thursday, on 01/17/10, an anonymous note was found on the floor of the administrator that E8 is abusing residents in this building. Th administrator spoke with the social services director to find out whether any one had reported abuse. Social Service director stated that she was aware that one of the certified nurse aides had got scratched by a resident. R31 was examined by the quality assurance nurse who stated that R31 had a scratch about 1 inch superficial scratch on the left hand near the wrist. 2. Review of the final abuse investigation on 02/14/10 denoted E7 was on 02/15/10 during am care on unit 1, The resident report that certified nurse aide was rough with her (R29). 3. Review of the final abuse investigation on 03/26/10 denoted on 03/25/10 the above resident (E6) was said to have taken $100.00 in exchange for a favor for the residents (R30). 4. Review of th abuse investigation denoted resident (R32) made statement that the social services designee (E9) took her money and stole	F 226		

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F 226	Continued From page 8 mail from her mail box. Review of the above allegation of abuse investigation preliminary 24 hour was not reported to the stated agency. Review of the Abuse Prevention Program Facility Procedures: V11. Initial Reporting of Potential abuse: (1). Initial Reporting of Allegation - If, during the course of an investigation, the administrator or designee had determined that there is reasonable cause to suspect mistreatment has occurred, the representative and the state agency shall be informed immediately. Within twenty-four hours after the occurrence, a written report shall be sent to the state agency. The written report should contain the following information date, time, location and circumstance of the alleged incident. The facility did not present any documentation that the 24 hour preliminary report to the state agency or a completed abuse investigation with date, time, location and circumstance of the alleged incident.	F 226		
F 246	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced	F 246		10/19/10

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F 246	Continued From page 9 by: Based on observation and interviews the facility failed to provide reasonable accomodation of needs for 3 residents inside the sample (R6, R7, R13) and one resident outside the sample (R28) who have expressed the desire to smoke cigarettes by not providing a alternate place to smoke during inclement weather as well as closing a enclosed smoking room without proper notice to the residents. This failure has the potential to affect the other 29 residents in the facility who smoke cigarettes. Findings include: On 9/9/10 R28 informed the Surveyor that residents could not smoke after 9pm. The facility had closed the enclosed smoking room without informing the residents. Residents can only smoke outside. No reason was given as to why the enclosed smoking room was closed. There was also no reason given as to when or if the smoking room would be reopened. During the daily status meeting, this concern was brought to the attention of E1 (administrator), E2 (director of nursing) and E3 (nurse consultant). E1 stated, "yes the smoking room was closed at the request of the owner." The survey team asked E1 if the smoking room was under construction. E1 stated, "no, it's not under repair. I don't have that answer We don't know why it was closed." E3 stated, "well have to talk with the owners." The facility was not able to provide evidence that there is an alternative place for residents to smoke. There is no plan in place to reopen the	F 246		

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F 246	Continued From page 10 smoking room so resident have a place to smoke when there is inclement weather or when the weather turns cold.	F 246		
F 250	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide medically related social services for 1 of 16 (R5)sampled residents, in regards to the resident's cancer status, resident desire to follow-up with a special doctor, resident's wishes to transfer to another, and parole status. In addition, the facility failed to contact the state agency's department for offenders the admission of 3 of 3 residents (R5, R28, R34) who are identified offender and obtained a harm risk assessment for each residents. Findings include: 1. R5 was admitted to the facility on 11/25/2009. R5 is a 74 year old resident on parole for a felony offense. On 9/08/2010 at 5:40pm, R5 told the surveyor he is seeking to be transferred to less restricted facility, for more independence. R5 stated prefers not to attend group activities. When asked about regular meeting with with facility's staff. Resident stated, two weeks ago he	F 250		10/16/10

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F 250	Continued From page 11 met with social services but nothing on regular basis. R5 states he does not recall the name of his doctor but desires follow-up with a cardio-doctor at local hospital, regarding a shunt placement. R5 denied he has prostate cancer. R5's medical record documented a history of prostate cancer. However, there is no orders or documented treatment. There is no labs results of establishing a R5 has prostate cancer. R5's care plan does have specific details of the condition of R5's parole. The information is a partial name of the parole officer, department of correction's general number and that he is to call twice month. There is goal or interventions to ensure the goal is met in the care plan. In addition, R5 has an diagnosis of congestive heart failure. The care plan did not address any possible discharge goals and conditions for discharge. On 09/09/2010 at 2:10pm, the surveyor asked E9 information about the condition of R5's parole, psychosocial program, and cancer status. E9 did not answer any questions. Instead, the surveyor was given computerize documentation, signed statements for R5 and hospital records. The signed statement dated 7/13/2010 with R5's name, stated the resident has exercised his right to psychosocial programming. Although client may benefit greatly from the social interaction and skills training recent attempts have been ignored. The care plan does not address any refusal for treatment. The computerize social service notes: -8/03/2010 progress about speaking with the parole officer. States client receives hospice.	F 250		

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F 250	Continued From page 12 -8/26/2010 behavior addressing client not reporting pain to nursing and hospice staff but to family member and other residents. -9/09/2010 visited resident to discuss possible transfer. There was no evidence of the resident being referred to the psychiatrist or psychologist for further intervention. Any scheduled one to one therapy. The care plan with the date of 12/01/2010 has a goal for the resident to meet with social services as tolerated. This is a non-measurable goal. The hospital documentation with a date of 8/30/2007 indicated R5 had a PSA (a marker for indicating prostate cancer) was a 4.2. The normal range was not present. The facility did not offer any follow-up to determine the status of R5's cancer at the time of his admission. On 9/16/2010 the surveyor obtained R5's lab for the prostate specific antigen (PSA) dated 3/09/2010. The PSA level 3.5 was normal. PSA reference range 0.0 - 4.0 ng/mg (nanogram/milligram) R5's medical record has a documented diagnosis of prostate cancer with no evidence of R5 having cancer. On 9/15/2010 at 2:45pm, the surveyor interviewed Z9 (parole officer) regarding R5's parole. Z9 told the surveyor he became R5's parole officer as July 29,2010. The previous parole officer (Z10) is on medical leave. Z9 stated, R5 is allowed to leave the facility and must not be involved in any crime as a condition of his parole. R5's medical record does not have updated information regarding his parole officer (with direct number for contact) and his department of	F 250		

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F 250	Continued From page 13 correction identification number. There was no evidence of social service obtaining a psychosocial history from the department of correction. 2. The facility present the survey team with 3 residents through a criminal background check, who were identified with a felony criminal offense. R5, R28, and R34 had no evidence that the state agency department for offenders, was informed of each resident's admission. The state agency's risk assessments were not completed for any of the residents. R5 was ordinally admitted 11/05/2010. R28 was originally admitted 3/03/2007. R34 was ordinally admitted 4/22/2009. On 9/08/2010 E1 reported she had no evidence of the state agency's department for offenders being contacted. However, she believed she did contact the department.	F 250		
F 252	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain a safe, clean, homelike environment for 11 of 39 resident's rooms on Unit 1 and Unit 2, by allowing resident's living and spaces to hold offensive odors, unclean equipment, mold on shower surface, not handling	F 252		10/15/10

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F 252	Continued From page 14 resident's care supplements in a sanitizing manner, torn window screen and disrepair wall & window. This failure has the potential to effect all the facility's 80 residents quality of life. Findings include: 1. 9/07/2010 between 9:15am and 10:15am, the surveyor conducted an initial tour accompanied by E18 (quality assurance nurse). The following observations were made: -Room 103 very stronger urine odor noted prior to entering the room. E18 reported 1 of 4 residents in the room having incontinence of bladder and bowel. No residents were present in the area at the time. -Room 106 with wall damage by the window. All the beds were made up. -Room 107 very strong urine odor. E18 confirmed there was 2 of 4 residents in the room identified with incontinence of bladder and bowel. No residents were present in the room. All the beds were made up. 2. 9/07/2010 at 2:28pm, the surveyor entered the facility's administrative office area and observed in the kitchen area boxes of supplies as follows: 3 stacks of large adult briefs, l stack of exam gloves and 1 stack of Fibersource HN (liquid dietary supplement). At that time E3 (nurse consultant) was made aware of the situation 3. 9/08/2010 at 10:05am the surveyor conducted an environmental tour of the facility's, while accompanied by E12 (maintenance supervisor) and E13 (housekeeping supervisor). The	F 252		

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F 252	Continued From page 15 following observations were made: -Toilet room share by residents in rooms 222 and 224, cigarette's burns on the toilet seat. Room 222's window frame had cigarette ashes and burns. -Unit's 2 men's shower room had wet floor. -Room 217 had a refrigerator with food items and no thermometer in the refrigerator. E12 informed the surveyor this was a resident's refrigerator and maintenance does not monitor the function of this refrigerator. -The toilet room used by resident in Room 215, had a slow running drain for the release of water in the sink. -One window in the Unit 2's laundry room was broken out. The facility placed a wooden board against the window. E12 told the surveyor, the facility has an order for a replacement window. However, the surveyor was not provide with evidence of this order prior to the exit. -Unit 2's soiled utility had an offensive odor. This room is directly in front of Unit 2's television viewing area. In addition, the refrigerator in the room was in need of defrosting. There was a build up of ice and frost. E12 confirmed this is the refrigerator used to store specimens. -The room with the facility's broiler had a window that was opened and had a torn window screen. -The toilet room used by residents in Room 212 and 210 had a sink with low water pressure. Not allowing a full force of water and appropriate hot water. E12 took temperatures with the facility's thermometer and for this sink, the temperature was 88 degrees Fahrenheit. -Unit 2's women's shower room had dirty equipment stored in the area. A soiled shower bed, shower chair and wheelchair cushion. E13 told the surveyor it was nurse's responsibility to	F 252		

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F 252	Continued From page 16 clean the resident's care equipment after use. In addition, the shower stall had mold on the tile surface and the grout between the tiles needed cleaning. -Rooms 206. 205, 204 had strong urine odors. In the toilet rooms used by 204 and 206 had multiple flies within the areas. E13 confirmed the unit's housekeeper had completed the cleaning for these rooms. No residents were present in the area at the time of the observation. -Unit 1's women shower room had a damaged counter top with the sinks. In this area was multiple spider webs with live spiders. The room had a cigarette odor. Unit 1's men shower/tub room also had spider webs with live spiders. The surveyor asked E12 to take a water temperature in the tub and a large amount of water ran over the room's floor.	F 252		
F 272	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems;	F 272		10/15/10

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F 272	Continued From page 17 Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation and record review and interviews the facility failed to initially and periodically perform comprehensive assessments in the areas of pain management, fall risk and appropriate diet, for 5 residents in the sample (R3, R4, R8, R11, R17). Findings include: 1. R8 is a 56 year old resident with diagnoses including diabetes mellitus, dysphagia and dehydration. On 9/7/10 R8 was observed during the lunch meal eating sliced ham, rice, spinach a slice of white bread and a beverage. Review of R8's clinical record shows a physician's order (initial date 5/5/10) for a Gluten free diet, sandwich at bedtime. The physician's progress notes dated 5/5/10 indicates R8 told her physician she has celiac disease. The physician's plan:	F 272		

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F 272	Continued From page 18 gluten free diet. R8 was observed again at 5:30pm eating dinner which consisted of spaghetti with meat sauce, corn, and 1 small slice of garlic (white) bread. Two surveyors asked R8 how was she enjoying the meal. R8 said fine and that she didn't have any problems. The diet card for R8 reads "NCS" (no concentrated sweets). At 5:35pm at the Unit II nurse's station E14 (food service supervisor) was asked if any residents received a special diet. E14 stated, "we don't have any special diets. The RD (Registered Dietitian) did the dietary assessment." At 6:00pm, the facility presented 2 nutritional assessments (printed from the computer) dated 2/10/10 (initial) and 6/8/10 (quarterly). The Initial assessment indicates R8 is on a regular diet. It was recommended to change the diet to NAS (no added salt), NCS (no concentrated sweets) for better blood pressure and diabetes control. The quarterly assessment (done by E14) documents R8 is on a regular diet, no chewing problem. There is no mention of dysphagia or celiac disease in either nutritional assessment. On 9/8/10 the facility presented an assessment dated 9/8/10. R8 informed the registered dietitian that certain foods she can't eat because of her bowels. On 9/14/10 at 3:20pm via telephone, Z3 stated, "I know she (R8) has pain al over her body, almost like fibromyalgia. No one indicated to me about a	F 272		

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F 272	Continued From page 19 nutritional assessment. I don't remember that diagnosis (Celiac disease)." There is no evidence that the facility thoroughly assessed R8 to determine if she indeed required a gluten free diet and if she truly has dysphagia. 2. R11 is a 60 year old with diagnoses including arthritis, ulcerative colitis, PVD (peripheral vascular disease and GERD (gastroesophageal reflux disease). R11 receives hemodialysis 3 times a week and has a fistula. The Comprehensive Pain Assessment dated 8/19/09 and 9/28/09 were the only ones noted in the clinical record. The last quarterly care plan addresses pain related to gout, osteoarthritis and PVD. The quarterly MDS (minimum data set) dated 7/19/10 indicates in the area of pain/comfort R11 scored 1/2 indicating pain less than daily/moderate pain. However, there's no indication of where, on his body, R11 experiences his pain. The September 2010 physician's order sheet shows order for Acetaminophen 325mg, 2 tablets by mouth every 6 hours as needed for pain/fever and Hydrocodone-APAP, 7.5-500, 1 tablet by mouth every 4 hours as needed for pain. On 9/9/10 at 11am, E2 (director of nursing) was asked if a more recent pain assessment was done on R11. E2 said she would check. At 11:55am, E2 stated, "we don't have any pain assessments for 2010." 3. R17 is a 51 year old with diagnoses including	F 272		

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F 272	Continued From page 20 Schizo-Affective disorder and Schizophrenia. On 9/7/10 during the medication pass observation Surveyor observed E4 (nurse) administer 3 medications to R17, one of them being Acetaminophen 325mg, 2 tablets (house stock) by mouth. The September 2010 physician's order indicates R17 can receive Acetaminophen 325mg, 2 tablets (650mg) by mouth every 8 hours for pain/elevated temperature. There is also an order for Acetaminophen Extra strength, 500mg caplet, take 2 tablets (1gm) by mouth 4 times daily as needed for pain/fever. During this observation E4 was note observed to assess if R17 was experiencing any pain or if she had a fever prior to administering the Acetaminophen. During the facility's presentation meeting on 9/9/10 at 9am, E2 (director of nursing) stated, "she (R17) has orders for regular strength and extra strength. I can't say why the nurse administered one over the other. She should have did an assessment." 5. R3 was observed on 09/07/10 at 10:15am sitting in a wheelchair in the dining room. R3 has diagnoses including Hypertension, Senile Dementia with Delusional Features, Seizures, Hypothyroidism and Schizo-Affective Disorder. Review of incident and accident for falls denotes R3 had fallen on 04/25/10, 06/24/10 and 07/26/10. Further review of these assessments denotes R3 was not assessed or reassessed	F 272		

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F 272	Continued From page 21 after each fall. 6. R4 was observed on 09/07/10 sitting in a chair in the dining room. Resident had a diagnosis Hyperthyroidism, Alzheimer, Pacemaker, Insomnia, Expressive Aphasia, Frontal Sinuitis, Orthostatic Hypotension, Cardio Syncope Episode and Anxiety. Review of the incident and accident reports denotes R4 had fallen on 04/08/10, 04/20/10, 05/09/10 and 08/07/10. Review of the fall assessment denotes R4 was not assessed or reassessed after each fall. 1. R3 was observed on 09/07/10 at 10:15 am sitting in the dining room. She was in a wheelchair. R3 had diagnosis Hypertension, Senile Dementia with Delusional Features, Seizure, Hypothyroid and Schizo Affective Disease. Review incident and accident for falls denotes R3 had fall on 04/25/10, 06/24/10 and 0726/10. Further review of the assessment denote the resident was not assessed or reassessed after each fall. 2. R4 was observed on 09/07/10 sitting in a chair in the dining room. Resident had a diagnosis Hyperthyroidism, Alzheimer, Pacemaker, Insomnia, Expressive Aphasia, Frontal Sinuitis, Orthostatic Hypotension, Cardio Syncope	F 272		

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F 272	Continued From page 22 Episode and Anxiety. Review of the incident and accident fall denotes R4 had fall on 04/08/10, 04/20/10, 05/09/10 and 08/07/10. Review of the assessment denoted the resident was not assessed or reassessed after each fall.	F 272		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation record review and interview the facility failed to periodically review and revise comprehensive care plans for 5 residents inside the sample (R3, R4, R5, R14)	F 280		10/15/10

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F 280	Continued From page 23	F 280		

and 4 residents outside the sample (R17, R20, R21, R23) who are at risk of falling or have been identified as high risk for falls. R17 and R5 sustained an injury after fallings and no planned interventions were updated.

Findings include:

1. R17 is is a 51 year old resident with diagnoses including dizziness and orthostatic hypertension.

Review of the Incident Accident log for 2010 shows R17 had 2 fall incidents.
On 3/9/10 while ambulating in the dining room, R17 lost her balance and fell. R17 complained of pain to her left ankle.
On 3/10/10 R17 was noted with bruising to the left ankle. R17 was sent to the hospital for evaluation and returned in the evening with a diagnosis of fracture of left fibula. R17 required a leg cast.

On 6/18/10 a 6:15am, R17 slipped in the shower. R17 complained of lower back pain. An Xray ordered for the lumbar spine was negative for fractures.

On 9/13/10 E2 (director of nursing) stated, "she (R17) entered the shower area without supervision. The staff didn't know she was in the shower."

On 9/14/10 at 2:10pm, R17 was interviewed in her room. Surveyor asked R17 had she had any falls within the last 6 months. R17 stated, "I fell in the dining room in March. I broke my ankle. I just slipped. I got the cast off April 27th. About 3 months ago, I felt dizzy and I slipped in the shower. No one was in there. I managed to get

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F 280	Continued From page 24 up and I told staff. I didn't bump my head but I did hurt my back. It was sore for a while." R17 was not noted wearing a orange wrist band during the time of this interview. However, R17's care plan did not reflect any revisions post falls. 2. On 9/07/2010 at 12:30pm, R5 reported he had recent falls in the facility. R5 claimed he fell in the men's shower room, while the floor was wet. R5 told the surveyor the floor in the shower room is wet all the time. R5 hurt his left leg and it swelled up and just recently went down to normal. The incidents reports had three incidents involving R5 as follows: -3/08/2010 at 5:45pm, resident observed on floor, in the room. Resident was ambulating at the time. R5 stated he attempted to turn off the light and lost his balance. R5 fell onto the floor on his buttock. Intervention taken: Body check/assessment done immediately-no injuries noted. MD (medical doctor) notified of incident-new orders received. Family notified. Safety re-eduction done, . -3/09/2010 at 7:20pm, resident observed on floor, in the room. Noted with hematoma to left side of head. Apparently lost balance and hit head in process. Intervention taken: body check/assessment done immediately, neuro check performed immediately and resident sent to emergency room(ER) for medical evaluation. -3/12/2010 at 5am in the bathroom, Patient stated that he bumped his left leg into the metal demarcation (unknown object) in the residents bathroom. Patient has two open areas on the left left and the area appear swollen. Intervention	F 280		

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F 280	Continued From page 25 taken for prevention: First aid given. Railings checked by maintenance in Unit 1 bedroom. No rough edges noted. Safety teachings reinforced. None of the facility's investigations for the above incidents address the cause of R5's fall and injury. The investigation did not go beyond the resident's statement to the staff. The care plan did not reflect any adjustment in the resident's monitor or supervision. Also no care plan intervention were changed. On 9/09/2010 at 11am, the surveyor asked E2 (director of nurse) in the presence of E3 (nurse consultant), why type of safety education was given to R5 after the fall on 3/08 and 3/12/2010? E2 was unable to tell the surveyor. 3.) R23 has diagnosis of cerebral palsy and grand-mal seizures. R23 had the following fall incidents: -1/22/2010 at 4:34pm, computerized documented fall at 1pm, in the corridor. R23 was wearing slippers. However, the hand written incident report documented 1/22/2010 at 8:45am, the fall incident in the corridor. -1/22/2010 at 3:20pm, hand written fell by nursing station. The intervention was increase supervision. -1/29/2010 at 9:30am in the television room. Resident was observed laying on the floor on the right side. -2/18/2010 at 3:45pm, unwitnessed fall by staff. However, another resident told staff resident started to get up and fell backward and hit his head. The incident took place in the dayroom. No investigation of the cause nor the factor surrounding the fall was noted. No change in the	F 280		

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F 280	Continued From page 26 care plan interventions. -8/12/2010 at 9:59pm, computerized documented a fall on 8/12/2010 at 6:30pm, in the hall. R23 sustained a bruise noted to the right side lower back. R23 observed getting up from a chair and ambulated pass the nursing station and fell. No change in the care plan interventions. The surveyor did not see any evidence of the interdisciplinary team to review this resident's care plan to determine how effective any of the previous intervention to prevent R23 from fall a fifth time. R23's care plan had multiple dates from 4/06/2009, 7/03/09, 9/28/09. 12/09, 3/28 and 6/20/2010. The care plan was not reviewed at the time of R23's falls. According to the facility's policy for fall prevention program: The care plan incorporates addressing each fall and interventions are changed with each fall, as appropriate. Immediate change in interventions that were unsuccessful. This was not implemented for R23. 4.) R4 was observed on 09/7/10 at 11:30 am sitting in chair dining room. Resident is alert and answer simple question. R4 was a 89 year old female with diagnosis Hypothyroidism, Alzheimer, Pacemaker, Insomnia Expressive Aphasia, Frontal Sinusitis, Orthostatic Hypertension, Cardio Syncope and Sinuitis. The Minimum Data Sets dated 04/20/10 and 06/18/10 denoted : Section J (4). Accidents fells in [past 30 days and fell in past 31 - 180 days. The fall incident and accident report denoted:	F 280		

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F 280	Continued From page 27 04/07/10 at 5:00 pm Call by resident that patient (R4) fell. Pt was walking around. Resident fell in Television room on knee. 04/20/10 at 9:50 am fell in dinning room. She was ambulating. Alert and disoriented normal for resident. Pupil response, pupils equal and reactive to light equal. Move all extremities. Blood pressure 198/132. Physician notified Z7 ordered received transfer to nearest emergency room. Resident noted with high blood pressure, lethargic, no apparent injury noted. 05/09/10 2:45 pm Resident observed on floor in dining room on unit 2. Resident unable to explain. No witness to fall. Re-educate on importance of waiting for assist from staff. 08/08/10 1:22 pm Fall observed on floor in television area. Resident was observed sitting on couch in television room. Resident was lying on side on floor. Resident fell and hit her head on the floor. Vital sign taken and transferred to emergency room. She will be going to Z1 hospital. Alert but confused. The fall risk assessment dated 04/20/10 at 1:30 pm denoted Resident is not at risk for falls. The fall care plan intervention and approaches was not updated or revised to prevent resident from further fall. 5.) R3 was observed on 09/07/10 at 10:15 am in the dining room. She was sitting in a wheelchair. She was also observed with right hand tremor/shaking continual. R3 was alert but unable to answer question. R3 has diagnosis Hypertension, Senile Dementia with Delusional Features, Seizure, Hypothyroid and Schizo Affective Disease.	F 280		

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F 280	Continued From page 28 The fall accident report denoted: 06/2410 at 8:40 am - R35 came out of her room and said that R3 was on the floor. So, myself (E22) and E2 (Director of Nurse) and one of the hospice aides went to the room to check it out and then we all picked her up off the floor. Resident was last seen in her room which she rolled herself to her room. The fall care plan intervention and approaches were not updated or revised to prevent resident from further falls. 6.) R20 with a history of a stroke had the following fall incidents: -2/06/2010 at 7am, observed resident in sitting position in bathroom. -computerized documentation 6/24/2010 at 8:30am, a fall in the bathroom. There were no revision of R20's care plan to reflect the falls. 7.) R21 has a diagnosis of dementia with behavior disturbance and a history of seizure. R21 had the following fall incidents: -3/21/2010 at 4:39am computerize documented fall incident. No care plan updated. 3/21/2010 at 2:00am. R21 was walking without shoes on on the side walk of building. No change in care plan interventions. -3/22/2010 9:45pm, resident found in room on floor. No care plan updated -On 4/07/2010 at 10:43pm, computerized documented fall 4/07/2010 at 3:45pm in the resident's room. Resident found on flooring on her stomach. No care plan updated. -On 7/03/2010 at 2:51pm, computerized documented fall. No care plan updated.	F 280		

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F 280	Continued From page 29 -7/03/2010 at 1pm, Resident found on the floor, in room. Resident sent out to hospital. Resident was alert-disoriented. Resident was last seen propelling self through out facility in her wheelchair. Intervention included the use of a pad alarm to wheelchair. The surveyor did not see any evidence of the interdisciplinary team to review this resident's care plan to determine how effective any of the previous intervention to prevent R21 from fall a fourth time. The care plan was not reviewed at the time of R21's falls. The care plan reviews were at 3/21, 3/22, 4/07 and 6/10/2010. According to the facility's policy for fall prevention program: The care plan incorporates addressing each fall and interventions are changed with each fall, as appropriate. Immediate change in interventions that were unsuccessful. This was not implemented for R21. 8.) R14 is a 53 year old resident with diagnoses including bipolar disorder, EPS tremors (extrapyramidal syndrome) and left leg cellulitis. R14 uses a wheel chair to move throughout the facility. The incident summary dated 8/30/10 indicates R14 reported to staff he was trying to transfer himself from his bed to his wheelchair when he fell onto his buttocks. This was a unwitnessed fall. R14's care plan was not updated to reflect this fall.	F 280		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281		10/15/10

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F 281	Continued From page 30 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to provide services that meet professional standards of quality by not: 1. notifying the physician of lab values for 2 residents outside the sample (R23 and R26). R23 had a repeat lab done which indicated a sub therapeutic valproic acid level. 2. documenting as ordered blood glucose levels for one resident inside the sample (R11) 3. taking blood pressure in correct extremity (R5) 4. cleansing insulin vial prior to drawing up medication per policy and procedure (R11) Findings include: 1.) R23 has a diagnosis of grand-mal seizures (severe seizures). R23's medication order for the last 3 months and currently September 2010; include Valproic Acid (anti-seizure medication) 500mg (milligram) three times daily. R23 had a lab dated 7/30/2010 for a Valproic acid level at 27.1(microgram/ milliliter). The labs reference range for a therapeutic level was at 10-100 mcg/mL. On 8/01/2010 there was an physician's order to repeat the lab (Valproic acid) in the morning. The surveyor could not find the results of the	F 281		

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re-draw for the lab, in R23's medical record. The surveyor asked E5 (nurse) for the lab. E5 called the laboratory company via phone to inquire about the lab, while in the present of the surveyor. E5 stated, the laboratory company reported the last lab was done 8/02/2010.

On 9/14/2010 the surveyor asked E2 (director of nurses) to provide the written documented. The surveyor reviewed the documented faxed over by the lab. The level documented was at 48.7mcg/mL, a low level. R23's medical record had no evidence of the physician being informed of this level as of 9/14/2010.

2.) R26 is a 62 year old resident with diagnoses including seizure disorder.

The standing orders indicates to obtain a Dilantin level every 3 months.
The order dated 8/10/10 orders for several labs including dilantin level.

During review of R26's clinical record another resident's lab results were noted in the record.

Surveyor brought this concern to E2 (director of nursing) attention. E2 stated, "I will check my binder. When we get the labs, I put them in my binder and I make a copy to put in the resident's chart."

At 10:10am, surveyor asked E2 if she found R26's lab results. E2 stated, "it was done, but I didn't have a copy in my book. The lab had to fax it to us. It was therapeutic (12.4mcg/mL). I want to call the physician before I give you a copy." Surveyor asked E2 if R26's physician was notified

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about the lab results. E2 stated, "we would have faxed the results to the physician if we had of had them."

3.) R11 is a 60 year old resident with diagnoses including diabetes mellitus.

During interview on 9/7/10 R11 informed surveyor that he receives hemodialysis 3 days a week.

The September 2010 physicians order sheet shows an order for blood glucose monitoring twice daily (6am and pm) and record. R11 is to receive Novolin R on a sliding scale for blood glucose levels 150 - 399, call physician if above 400 or below 70.

Review of the August Glucose Monitoring Record shows blood glucose level ranging from 162 - 318mg/dl. There is no documentation on this form nor in the nurse's notes that insulin per sliding scale was given.

On 9/9/10 at 11am, Surveyor brought this concern to E2 (director of nursing). E2 stated, "sometimes he refuses." Surveyor asked if this was the form the nurse's are to record the residents's blood glucose levels on. E2 stated, "yes, this is the flow sheet they are to document on. Let me see if the nurse's documented on another sheet."

Further review of the August Glucose Monitoring Record indicates
R11 refused the sliding scale insulin 3 times and was out on pass 2 times.
The June and July 2010 MAR (medication administration record) does not show R11's blood

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F 281	Continued From page 33 glucose levels were documented as done or that he refused to have them done. 4.) R5 is a 74 year old resident with diagnoses including osteoporosis, prostate cancer and depression. On 9/8/10 during the medication pass observation E5 (nurse) took R5's blood pressure in the left wrist with a wrist cuff machine. The September 2010 physician's order sheet shows an order to take BP (blood pressure) daily in right arm. E5 did not follow physician's order in taking R's blood pressure in the right arm.	F 281		
F 323	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: A.) Based observation interview and record review the facility failed to adequately supervise residents, evaluate the circumstances and/or the reason of falls, implement planned interventions, or follow the facility's fall policy to prevent falls; for 7 of 16 sampled residents (R3, R4, R5, R6, R12, R13, R14) and 7 supplementary residents (R17,	F 323		10/15/10

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F 323	Continued From page 34 R20, R21, R22, R23, R24, R27) to avoid falls with the risk of injury. B.) Based on observation and interview the facility failed to eliminate environmental hazards within the facility's interior and exterior areas, areas used by all the ambulatory residents.The facility failed put in place safety mechanisms to ensure falls are avoided for the residents. As a result of the above facility's failures R5, R13, R17, R23 and R27 had an injury after falling. R5 and R17 had a fall directly related to one of the facility's environmental hazards that existed at the time of the survey. R6, R12, R13 and R24 had a fall unwitnessed by a facility staff member, on the exterior of the facility. R3, R4, R5, R12, R17 and R23 had a fall or falls unwitnessed by a facility staff member. R27 has a history of substance abuse and suspected alcohol usage. R27 was granted a community pass, and reported to have had 3 falls resulting in injuries, in which no facility interventions were put in place to prevent further falls or adequate supervision. This failure to provide a safe environment to prevent fall accident hazards and the failure to provide supervision/interventions after resident's falls have occurred resulted in an Immediate Jeopardy.The Immediate jeopardy was noted to have begun on 09-13-2010 when residents were identified to be in immediate jeopardy of safety on 9/13/2010. The survey team informed the administrator (E1) in the presence of director of nurses (E2) and the nurse consultant (E3) of the immediate jeopardy, on 9/13/2010 at 2:45pm.	F 323		

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F 323	Continued From page 35 . Findings include: 1.) On 9/07/2010 at 12:30pm, R5 reported he had recent falls in the facility. R5 claimed he fell in the men's shower room, while the floor was wet. R5 told the surveyor the floor in the shower room is wet all the time. R5 hurt his left leg and it swelled up and just recently went down to normal. The incidents reports had three incidents involving R5 as follows: -3/08/2010 at 5:45pm, resident observed on floor, in the room. Resident was ambulating at the time. R5 stated he attempted to turn off the light and lost his balance. R5 fell onto the floor on his buttock. Intervention taken: Body check/assessment done immediately-no injuries noted. MD (medical doctor) notified of incident-new orders received. Family notified. Safety re-eduction done, . -3/09/2010 at 7:20pm, resident observed on floor, in the room. Noted with hematoma to left side of head. Apparently lost balance and hit head in process. Intervention taken: body check/assessment done immediately, neuro check performed immediately and resident sent to emergency room(ER) for medical evaluation. -3/12/2010 at 5am in the bathroom, Patient stated that he bumped his left leg into the metal demarcation (unknown object) in the residents bathroom. Patient has two open areas on the left left and the area appear swollen. Intervention taken for prevention: First aid given. Railings checked by maintenance in Unit 1 bedroom. No rough edges noted. Safety teachings reinforced.	F 323		

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F 323	Continued From page 36 None of the facility's investigations for the above incidents address the cause of R5's fall and injury. The investigation did not go beyond the resident's statement to the staff. The care plan did not reflect any adjustment in the resident's monitor or supervision. Also no care plan intervention were changed. On 9/09/2010 at 11am, the surveyor asked E2 (director of nurse) in the presence of E3 (nurse consultant), why type of safety education was given to R5 after the fall on 3/08 and 3/12/2010? E2 was unable to tell the surveyor. 2.) On 9/07/2010 one of the surveyor approached R13 to inquire about a bandage attached to his head. R13 told the surveyor he fell, while outside. According to R13 record, R13 had a history of left hip fracture, and seizure disorder The computerized incident report dated 9/01/2010, documented R13 had a fall incident at 9am on 9/01/2010, while outside. R13 was in a chair (wheelchair) at the time. R13 was noted to have a laceration to the left forehead, and transferred to the ER. The incident was not witnessed by any staff member. The hospital emergency room record, stated R13 had a head injury. "The skull and/or brain were affected." The investigations conducted by the facility consist of R13`s statement at the time of the incident. According to one part of the	F 323		

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investigation. The wheelchair was locked during the incident. R13 leaned and fell out the chair. Another part of the documented investigation, documented R13 stated that he was in the wheel chair when the rubber part of the small wheel came completely off. Wheelchair leaned side way and resident had fall.

On 9/09/2010 at 4:18pm, the surveyor met with R13 to discuss the incident. R13 told the surveyor he was being pushed by another resident, going across the street. While being push over pot holes and bumps one of the wheels rubber came off. The chair tilt, he leaned and fell to the ground. E12 was in R13's room at the time, R13 told the surveyor E12 replaced the wheel. E12 confirmed he replaced the wheel on R13's wheelchair.

The surveyor reviewed R13's care plan's dated 8/10/2010 had added to the goal of resident will not sustain a fall-related injury the following interventions, 9/01/2010 resident will inform staff regarding any repairs needed to wheelchair. Encourage resident to allow staff to assist with cleaning and maintenance of wheelchair. Encourage resident to ask for assistance. None of these intervention address how R13's wheelchair became in disrepair, nor what regular maintenance including monitoring the staff will do to prevent it from happening again.

3.) R17 is is a 51 year old resident with diagnoses including dizziness and orthostatic hypertension.

Review of the Incident Accident log for 2010 shows R17 had 2 fall incidents.

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On 3/9/10 while ambulating in the dining room, R17 lost her balance and fell. R17 complained of pain to her left ankle.
On 3/10/10 R17 was noted with bruising to the left ankle. R17 was sent to the hospital for evaluation and returned in the evening with a diagnosis of fracture of left fibula. R17 required a leg cast.

On 6/18/10 a 6:15am, R17 slipped in the shower. R17 complained of lower back pain. An Xray ordered for the lumbar spine was negative for fractures.

On 9/13/10 E2 (director of nursing) stated, "she (R17) entered the shower area without supervision. The staff didn't know she was in the shower."

The quarterly MDS (minimum data set) dated 8/17/10 shows R17 scored 2 in cognitive skills for daily decision making which indicates moderately impaired - decisions poor; cues/supervision required. In walking and personal hygiene/bathing, R17 scored 1/2 which indicates supervision/setup help only.

On 9/14/10 at 2:10pm, R17 was interviewed in her room. Surveyor asked R17 had she had any falls within the last 6 months. R17 stated, "I fell in the dining room in March. I broke my ankle. I just slipped. I got the cast off April 27th. About 3 months ago, I felt dizzy and I slipped in the shower. No one was in there. I managed to get up and I told staff. I didn't bump my head but I did hurt my back. It was sore for a while."
R17 was not noted wearing a orange wrist band during the time of this interview.

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F 323	Continued From page 39 4.) R27 is a 55 year old resident with a history of alcohol abuse and diagnosis of Schizophrenia. According to an incident report. On 1/05/2010 at 10:20pm, R27 returned to the facility from a community pass, a bloody face. He stated he fell three times. R27 was noted with the smell of alcohol on his breath. R27 was sent out to the ER and returned after receiving 5 sutures above his left eyebrow. There was no investigation beyond the resident's statement. No confirmation on the use of alcohol. No intervention regarding inappropriate behavior while on pass. The intervention included counseled on alcohol abuse. The resident's care plan during the time period does not reflect the resident was in a rehabilitative program addressing alcohol abuse with mental illness. On 9/14/2010 at 4:15pm, the surveyor interviewed E9's (social service director) about the intervention taken post R27's 2/02/2010 incident. E9 stated R27 still has a community pass privileged. Now he is on a level two, where he can go out with a staff member or a family member. The surveyor asked about the program R27 was attending. R27 was not listed among the residents attending the outside MISA (mental illness substance abuse) program, offered by the facility. E9 told the surveyor R27 was evaluated last Thursday (9/09/20100 and would attend by tomorrow (9/15/2010). The facility's resident behavior management and outside pass program stated the inappropriate and unacceptable behaviors including but not limited to : using non-prescribed drugs or alcohol: will result in immediate pass suspension.	F 323		

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F 323	Continued From page 40 5.) R23 has diagnosis of cerebral palsy and grand-mal seizures. R23 had the following fall incidents: -1/22/2010 at 4:34pm, computerized documented fall at 1pm, in the corridor. R23 was wearing slippers. However, the hand written incident report documented 1/22/2010 at 8:45am, the fall incident in the corridor. -1/22/2010 at 3:20pm, hand written fell by nursing station. The intervention was increase supervision. No investigation to determine any one of the record falls. -1/29/2010 at 9:30am in the television room. Resident was observed laying on the floor on the right side. Intervention use of chair alarm when out of bed and pad alarm while in bed. -2/18/2010 at 3:45pm, unwitnessed fall by staff. However, another resident told staff resident started to get up and fell backward and hit his head. The incident took place in the dayroom. No investigation of the cause nor the factor surrounding the fall was noted. No change in the care plan interventions. No documentation of the use of the chair alarm and going off to alert staff members of R23's movement. -8/12/2010 at 9:59pm, computerized documented a fall on 8/12/2010 at 6:30pm, in the hall. R23 sustained a bruise noted to the right side lower back. R23 observed getting up from a chair and ambulated pass the nursing station and fell. No change in the care plan interventions. No documentation of the use of the chair alarm and going off to alert staff members of R23's movement and staff intervention at the time. The surveyor did not see any evidence of the interdisciplinary team to review this resident's	F 323		

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F 323	Continued From page 41 care plan to determine how effective any of the previous intervention to prevent R23 from fall a fifth time. R23's care plan had multiple dates from 4/06/2009, 7/03/09, 9/28/09. 12/09, 3/28 and 6/20/2010. The care plan was not reviewed at the time of R23's falls. According to the facility's policy for fall prevention program: The care plan incorporates addressing each fall and interventions are changed with each fall, as appropriate. Immediate change in interventions that were unsuccessful. This was not implemented for R23. 6.) On 9/07/2010 between 10am and 2:40pm the surveyor observed R6 ambulating outside the facility's building in the park lot and sitting areas. On 8/07/2010 at 2:40pm, interviewed the resident in the lounge located in Unit 1. R6 had a orange wrist band on one of wrist. R6 told the surveyor he was in a shelter care facility prior to his admission to the facility three years old. R6 told the surveyor he was hit by a car and woke up at the facility. On 9/08/2010 at 9:40am, 11:20am, and 3:35pm, R6 was observed ambulating outside the facility around the front of the building and park lot area. R6 was not engage in any activity with any resident and no staff was present in the area. On 9/09/2010 during an interview with E2 (director of nurses), the surveyor was told that the leaf on any resident's room door or head of bed and the present of an orange wrist band; meant that resident was high risk for floor. This was initiated in July 2010.	F 323		

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F 323	Continued From page 42 R6 had the following computerize incident report with accompanying investigation: -4/24/2010 10:14pm, Fall incident at 4:45pm, outside. Observed on ground by peer, who notified staff. - 05/07/2010 12:50pm, Fall incident date 4/24/2010 at 10:14pm. The resident was located outside the facility at the time. R6 reported he tripped. The surveyor could not determined if these two dates were two separated reported fall incident or the same one. On 9/09/2010 the surveyor questioned E2 (director of nurses) since she filled out and signed the staff interview post accident/incident sheet dated 4/24/2010. E2 confirmed the documentation above both refer to the incident on 4/24/2010 and it occurred at 4:45pm, but charted at 10:14pm. The management follow up to incident had no investigation beyond the incident report. There is no interview of the witness, a peer. There was no investigation done to determine the cause and/or the factors that cause R6 go fall. The intervention was to monitor on unit and grounds. This intervention was not observed implemented on 9/07 and 9/08/2010, while R6 ambulated outside without visual supervision from staff. 7.) R12 is a 53 year old resident admitted to the facility on 7/28/2010. R12 has diagnosis including but not limited to dementia and seizures disorder. R12 had a physician order initially dated	F 323		

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F 323	Continued From page 43 7/28/2010 for chair alarm, when up in chair for safety. The surveyor did not note any discontinue orders for this chair alarm in place up to the current physician' order for September 2010. On 9/07/2010 at 4:35pm, R12 was positioned in a geriatric chair in the Unit 2 television viewing area. R12 was placed in the lowest reclining position of the chair. E19 (certified nurse aide) who was in the area at the time, told the surveyor R12 was in the chair like that, because he tries to get up. On 9/09/2010 at 10:46am, the surveyor observed R12 in the Unit 2's television viewing area, in the geriatric chair. R12 was making several attempts to sit up in the chair. R12 told the surveyor he wanted to sit up. On 9/09/2010 at 12:00pm, E20 (nurse aide) who was taking care of R12, was questioned about the use of a chair alarm. E20 stated she was not aware of the use of an alarm. E20 told the surveyor she had taken care of R12 before this day. R12 had the following documented fall incidents: -7/29/2010 at 10:27pm, unwitnessed in room, resident was found on the floor. Protective device in use: pad alarm secondary to risk for fall. The investigation consist of the resident's statement: He was getting out of bed to go to the bathroom. Interventions stated put in place: assessed for injury and pain. Redirected to use call light for assistance and not try to get out of bed by himself. Pad alarm in place. Orange band/leaf to identify risk for falls.	F 323		

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F 323	Continued From page 44 -Computerize incident 8/17/2010 documented 7:41am, at 4:30am while making rounds, resident observed on floor. Resident in a sitting position. Resident stated he was trying to got to toilet without assistance. Interventions stated put in place:assessed for injury and pain. Redirected to use call light for assistance and not try to get out of bed by himself. Pad alarm in place. Orange band/leaf to identify risk for falls. Both investigations had the same information. No change in any interventions. Nothing about staff member being alerted to the pad alarm, if it was applied. Nothing about toileting the resident. During the survey, the surveyor noted the use of incontinent pads/briefs in use for R12. The facility's policy for fall prevention program stated: Residents at risk of falling will be assisted with toileting needs in accordance with voiding patterns identified during the assessment process and as addressed on the plan of care. This was not implemented for R12. Care plan dated 8/02/2010 had problem with poor balance and goal to be free from a fall related injury and problem of history of seizure and goal of not experience any injury from seizure activity through 11/02/2010. No falls were noted as a problem in the the care plan. 8.) -R14 is a 53 year old resident with diagnoses including bipolar disorder, EPS tremors (extrapyramidal syndrome) and left leg cellulitis. R14 uses a wheel chair to move throughout the facility.	F 323		

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F 323	Continued From page 45 The incident summary dated 8/30/10 indicates R14 reported to staff he was trying to transfer himself from his bed to his wheelchair when he fell onto his buttocks. This was a unwitnessed fall. The quarterly MDS dated 7/5/10 The quarterly MDS (minimum data set) dated 8/17/10 shows R14 scored 2 in cognitive skills for daily decision making which indicates moderately impaired - decisions poor; cues/supervision required. In transfer and in walking, R14 scored 2/2 which indicates limited assistance/one person physical assist. 9.) R4 was observed on 09/7/10 at 11:30 am sitting in chair dining room. Resident is alert and answer simple question. R4 is a 89 year old female with diagnosis Hypothyroidism, Alzheimer, Pacemaker, Insomnia Expressive Aphasia, Frontal Sinusitis, Orthostatic Hypertension, Cardio Syncope and Sinuitis. The Minimum Data Sets dated 04/20/10 and 06/18/10 denoted : Section B: (4). Cognitive Skill for Daily Decisions-Making was score 2 moderate impaired - decision poor, cues/supervision required. Section J (4). Accidents fells in [past 30 days and fell in past 31 - 180 days. The fall incident and accident report denoted: 04/07/10 at 5:00 pm Call by resident that patient (R4) fell. Pt was walking around. Resident fell in Television room on knee. 04/20/10 at 9:50 am fell in dinning room. She was ambulating. Alert and disoriented normal for	F 323		

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F 323	Continued From page 46 resident. Pupil response, pupils equal and reactive to light equal. Move all extremities. Blood pressure 198/132. Physician notified Z7 ordered received transfer to nearest emergency room. Resident noted with high blood pressure, lethargic, no apparent injury noted. 05/09/10 2:45 pm Resident observed on floor in dining room on unit 2. Resident unable to explain. No witness to fall. Re-educate on importance of waiting for assist from staff. 08/08/10 1:22 pm Fall observed on floor in television area. Resident was observed sitting on couch in television room. Resident was lying on side on floor. Resident fell and hit her head on the floor. Vital sign taken and transferred to emergency room. She will be going to Z1 hospital. Alert but confused. The fall risk assessment dated 04/20/10 at 1:30 pm denoted Resident is not at risk for falls. There was no assessment or reassessment for resident after each fall. The fall care plan intervention and approaches were not updated or revised to prevent resident from further fall. 10.) R3 was observed on 09/07/10 at 10:15 am in the dining room. She was sitting in a wheelchair. She was also observed with right hand tremor/shaking continual. R3 was alert but unable to answer question. R3 has diagnosis Hypertension, Senile Dementia with Delusional Features, Seizure, Hypothyroid and Schizo Affective Disease. The Minimum Data Sets dated 07/29/10 denoted: Section B. (4). Cognitive Skills For Daily Decision-	F 323		

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F 323	Continued From page 47 Making was score 2 - moderately impaired - decisions poor, cues/supervision required. The fall accident report denoted: 06/2410 at 8:40 am - R35 came out of her room and said that R3 was on the floor. So, myself (E22) and E2 (Director of Nurse) and one of the hospice aides went to the room to check it out and then we all picked her up off the floor. Resident was last seen in her room which she rolled herself to her room. Continue review of the fall accident report denoted that the following dates 04/25/20 and 07/26/20 their was no investigation completed. There was assessment or reassessment of the above fall incidents. The fall care plan intervention and approaches were not updated or revised to prevent resident from further falls. 11.) R20 with a history of a stroke had the following fall incidents: -2/06/2010 at 7am, observed resident in sitting position in bathroom. Interventions instructed to wear shoes at all time. No investigation of why R20 fell and any how the fact of having no shoes, contributed to the fall. -computerized documentation 6/24/2010 at 8:30am, a fall in the bathroom. However, the written investigation stated resident was found of floor, in the hallway. There was no investigation to determine why the resident fell and no change intervention.	F 323		

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F 323	Continued From page 48 12.) R21 has a diagnosis of dementia with behavior disturbance and a history of seizure. R21 had the following fall incidents: -3/21/2010 at 4:39am computerize documented fall incident 3/21/2010 at 2:00am. R21 was walking without shoes on on the side walk of building. No investigation and no change in interventions. Post fall R21 instructed on safe use of assistive device. Safe transfer techniques. Use of call light . Resident exited back door and exit alarm sound. The report documented R21 was alert but confused. Cognitively impaired Unable to interview. -3/22/2010 9:45pm, resident found in room on floor. The investigation did not go beyond the incident report. The intervention were Complete body assessment. Safety teaching reinforced. Matt at bedside. Bed in lowest position. Medication for agitation as needed Increase superversion when resident is anxious or agitated state. Medication review by DON(director of nurses). No conclusion to the investigation. No indication R21 had a behavior before the fall. -On 4/07/2010 at 10:43pm, computerized documented fall 4/07/2010 at 3:45pm in the resident's room. Resident found on flooring on her stomach. Intervention -reeducated to safety issues. Staff to initiated every 15 minute checks, after R21's return to the facility. The reason for R21's fall was not investigated for proper care planning of interventions. -On 7/03/2010 at 2:51pm, computerized documented fall 7/03/2010 at 1pm, Resident found on the floor, in room. Resident sent out to hospital. Resident was alert-disoriented. Resident was last seen propelling self through out facility in her wheelchair. Intervention included the use of a	F 323		

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F 323	Continued From page 49 pad alarm to wheelchair. The surveyor did not see any evidence of the interdisciplinary team to review this resident's care plan to determine how effective any of the previous intervention to prevent R21 from fall a fourth time. The care plan was not reviewed at the time of R21's falls. The care plan reviews were at 3/21, 3/22, 4/07 and 6/10/2010. According to the facility's policy for fall prevention program: The care plan incorporates addressing each fall and interventions are changed with each fall, as appropriate. Immediate change in interventions that were unsuccessful. This was not implemented for R21. 13.) R22 has a diagnosis of a stroke and mental retardation with an unsteady gait. R22's minimum data set dated 2/14/2010 indicated R22 had a fall within the past 30 days. Incidents reports and fall investigations documented the following: -3/16/2010 at 6:40pm, unwitnessed fall in the dining area on the floor. Resident called for help. The investigation does not include any cause or possible factors contributing to R22's fall. -4/01/2010 at 9:12pm, computerized fall documented a fall on 4/01/2010 at 4:15pm while in the dining room. Resident found lying on left side. The investigation does not include any cause or possible factors contributing to R22's fall. R22's 3/06, 6/16/2010 care plan reviews had no change in interventions. On 9/07/2010 at 10:15am, initial tour of the facility, the surveyor observed the dining area in questioned was located directly across the unit's nurse station. According to the facility's policy for fall prevention	F 323		

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F 323	Continued From page 50 program: The care plan incorporates addressing each fall and interventions are changed with each fall, as appropriate. Immediate change in interventions that were unsuccessful. This was not implemented for R22. 14.) On review of the facility's incident reports the surveyor noted the following concerning R24: -6/21/2010 at 9:55am, computerized documented fall on 6/21/2010 at 9am, resident had a fall outside the facility. Resident sustained a brusing/skin tear. Resident stated she slipped when she was rising from chair. The resident reported the fall to the nurse. First aid was applied to right elbow and right knee. The intervention was that resident would let staff know her where about. No investigation surrounding the fall. 15.) On 9/07/2010 at 9:35am, the survey team entered the facility. While ambulating to the front entrance of the facility. The surveyor shoe fell with in a crack of the sidewalk and lost balance but did not fall. The surveyor observed residents from the facility's Unit 1, ambulating and wheeling themselves out the entrance onto the sidewalk and park lot. The cracks in the sidewalk pavements, cause a tripping hazard for residents. At 11:45am and 4pm, the surveyor observed unnamed residents (and R6) ambulating within the facility's park lot. This park lot had a large pot hole with unlevel surfaces, causing a tripping hazard for residents. On 9/08/2010 between 10:05am and 11:15pm, the surveyor conducted an environmental tour of the facility, while accompanied by E12	F 323		

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F 323	Continued From page 51 (maintenance director) and E13 (housekeeping director). The surveyor noted the facility has four community bathing/shower areas available for all residents. The unit 2's men shower room had a wet floor. E13 commented a resident just got out the shower, and the housekeeper would mop it up. The surveyor noted no non-slip surface in the shower stall, and the floor directly outside the shower curtain. There was no rug nor any other method for absorbing the excessive water from the shower. -The unit 2's women shower room had no non-slip surface in and directly outside the shower curtain. Each Unit 2 shower room had a shower stall that was leveled with the room's floor. However, the unit 1's women and men shower rooms had a tub/shower combination. The tub did not have a complete non slip surface inside the tub. The top of the tub was at least 1 1/2 feet above the floor level. This require residents to step into and out of the tub. The grab bar was attached to the left side of the tub, facing the faucet of the tub. -While testing the water temperatures in the Unit 1's men shower/bath, the surveyor noted an excessive amount of water pooling over the floor outside the tub. This also, created a tripping hazard for the residents. Although the Immediacy was removed on 09/14/2010, the facility remains out of compliance at severity level two in order to allow for the implementation of the facility's plan and allow time for the facility to evaluate their interventions. The immediate jeopardy was removed on 9/14/2010 at 11:50am. The facility took the following steps to remove the immediacy:	F 323		

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F 323	Continued From page 52 1. All residents who are at risk for falls were re-assessed on 9/13/2010. Non-skid mats were placed in each shower stall and bathtub on 9/13/2010. The pot holes in the parking lot were repaired on 9/08 and 9/13/2010. The cracks in the side walk at the front entrance were repaired on 9/08/2010 and other areas checked and repaired as needed. Maintenance director repaired the leak in the Unit 1 bathroom on 9/08/2010. 2. Initiated an emergency resident council meeting on 9/13/2010 to inform the residents that they are not allowed to push other residents in wheelchairs. Those residents who did not attend, met with activity director 1 to 1 on 9/13/2010 and will continue until all residents are notified. 3. An in-service was initialed on 9/13/2010 to inform all staff that residents are not allowed to push each other in wheelchairs. Also all staff was in-serviced to ensure their knowledge of the fall prevention program, up to and including identifying those residents who are at risk for falls through the use of orange armbands and orange leaves. To be completed by 9/14/2010 for all staff currently on duty. Staff members not present in services will be ongoing until all staff has been informed. 4. The management follow-up form (utilizes as an investigation form) has been revised to include the "because factor" in an effort to better identify possible causes of incidents. The administrator, maintenance director, Director of nursing or designee will monitor during routine	F 323		

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F 323	Continued From page 53 environmental rounds inside and outside several times daily including weekends to ensure compliance. Any finding will be brought to the Administrator's attention and Monthly QA (Quality assurance) meeting for discussion and/or resolutions.	F 323		
F 325	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to thoroughly assess one resident in the sample (R8) to determine if there was a nutrition problem that warranted the need for a Gluten free diet as ordered by the physician. Findings include: -R8 is a 56 year old resident with diagnoses including diabetes mellitus, dysphagia and dehydration. On 9/7/10 R8 was observed during the lunch	F 325		10/15/10

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F 325	Continued From page 54 meal eating sliced ham, rice, spinach a slice of white bread and a beverage. Review of R8's clinical record shows a physician's order (initial date 5/5/10) for a Gluten free diet, sandwich at bedtime. The physician's progress notes dated 5/5/10 indicates R8 told her physician she has celiac disease. The physician's plan: gluten free diet. R8 was observed again at 5:30pm eating dinner which consisted of spaghetti with meat sauce, corn, and 1 small slice of garlic (white) bread. Two surveyors asked R8 how was she enjoying the meal. R8 said fine and that she didn't have any problems. The diet card for R8 reads "NCS" (no concentrated sweets). At 5:35pm at the Unit II nurse's station E14 (food service supervisor) was asked if any residents received a special diet. E14 stated, "we don't have any special diets. The RD (Registered Dietitian) did the dietary assessment." At 6:00pm, the facility presented 2 nutritional assessments (printed from the computer) dated 2/10/10 (initial) and 6/8/10 (quarterly). The Initial assessment indicates R8 is on a regular diet. It was recommended to change the diet to NAS (no added salt), NCS (no concentrated sweets) for better blood pressure and diabetes control. The quarterly assessment (done by E14) documents R8 is on a regular diet, no chewing problem. There is no mention of dysphagia or celiac disease in either nutritional assessment.	F 325		

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F 325	Continued From page 55 On 9/8/10 the facility presented an assessment dated 9/8/10. R8 informed the registered dietitian that certain foods she can't eat because of her bowels. On 9/14/10 at 3:20pm via telephone, Z3 stated, "I know she (R8) has pain al over her body, almost like fibromyalgia. No one indicated to me about a nutritional assessment. I don't remember that diagnosis (Celiac disease)." There is no evidence that the facility thoroughly assessed R8 to determine if she indeed required a gluten free diet and if she truly has dysphagia.	F 325		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		10/15/10

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This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview the facility failed to ensure that 2 of 16 sampled residents (R6 and R12) does not receive medications without proper monitoring and appropriate usage of an as needed medication. R6 was given cough medication without an assessment for the proper usage. R12 receives blood thinner and anti-seizure medications, which requires a therapeutic level be maintain for effective usage. However, there was no baseline and/or routine plan for monitoring the medications.

Findings include:

1. R6 us a 54 year old resident, with diagnoses of schizoaffective disorder, alcohol dependence and depression. R6 current medication orders for September 2010 included: Robitussin DM cough syrup, 10ml (milliliters) every 6 hours as needed. The surveyor did not find any chronic condition for R6 that would cause for the use of cough syrup.

On 9/07/2010 between 2:40pm and 3:30pm, the surveyor observed as R6 ambulated between outside, facility corridors and Unit 1's nurse station. At 3:25pm the surveyor observed E5 (nurse) give R6 a red liquid substance in a small medicine cup. On interview with E5
told the surveyor she gave R6 cough syrup because he stated he had a cough and was

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F 329	Continued From page 57 congested. There was no nursing assessment made to determine if R6 had a cough or chest congestion. On 9/08/2010 during the daily status meeting conducted at 5:00pm, the surveyor asked E2 (director of nurses) how would the nurses determine the use of the cough medicine. E2 stated, he told the nurse he had a cough. The surveyor asked for any physical assessment or sign of a chronic cough. The nurse's handbook 2010 edition for medication, indicates with use of this medication (dextromethorphan hydrobromide/ Robitussin), to monitor cough type and frequency. 2. R12 is a 53 year old resident with diagnoses including but not limited to: seizure disorder and GI (gastric intestinal) bleeding. R12's medication orders for September 2010 included: Valproic Acid 250mg (milligram) twice daily, Seroquel 100mg every night and Heparin 5000 unit sublingual every eight hours. R12 was admitted to the facility on 7/28/2010. The physician's order sheet for September 2010, does not have any orders for labs to detect levels of Valproic Acid/ Depakote, Prothrombin Time (PTT)/international ratio (INR) levels or eye examination. -Seroquel over long term use, effects eye health and monitoring for changes for the condition of the eye is indicate with use. R12 had no record or documented eye examination for a based line condition. -Valproic Acid/ Depakote a seizure medication, is indicated for monitoring for therapeutic blood level to prevent seizure.	F 329		

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F 329	Continued From page 58 -PTT/INR is indicated how thin the blood flow within the blood vessel. This alert medical staff of possible risk of bleeding. On 9/09/2010 during the 5:15pm daily status meeting, the surveyor informed the facility administrative staff, including E1 (administrator) and E2 (director of nurses), of the above concerns for R12's monitoring. On 9/13/2010 E1 presented hospital labs for the INR, PTT and Valproic Acid. The PTT level 7/25/2010 at at 42.8 (high) (Reference range 25-34.5). Valproic Acid 8/23/2010 4 (low) (Reference range 50-100 ug (microgram)/ dL (deciliter). These were abnormal labs that were not follow-up or notified by R12's current physician.	F 329		
F 332	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews the facility failed to ensure that it is free of a medication error rate of five percent or greater by: -failing to administer medications as ordered by the physician for 1 resident (R18) and not notifying the physician of the resident's request -not following manufacturer's recommendations for ora medications for 1 resident inside the sample (R5) and 1 outside the sample (R19).	F 332		10/15/10

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F 332	Continued From page 59 There were 41 opportunities observed with a total of 3 errors. This resulted in a medication error rate of 7.3%. The facility also failed to follow their Medication Administration Policy. Findings include: 1. On 9/7/10 between 4:25pm and 5:30pm, the following observations were made: -Surveyor observed E4 (nurse) pass medications to R18. E4 informed the Surveyor that R18 takes her 5pm and 9pm medications together. R18 received 3 medications by mouth, Ferrous Sulfate 325mg, Premarin 0.3mg and Zetia 10mg. Review of the September 2010 POS (physician's order sheet) indicates R18 is to receive Zetia, take 1 tablet by mouth at bedtime (9pm). There is no indication that R18's physician was contacted regarding R18's request to take the Zetia at 5pm instead of 9pm. According to the 2010 Nursing Drug Handbook Zetia is a selective cholesterol absorption inhibitor. -At approximately 5:20pm, E4 administered 2 medications to R19. One of the medications was Lithium Carbonate, 300mg capsule. by mouth. The instructions on the medication card reads "Take with plenty of water". E4 gave R18 less than 4 ounce of water to take both medications. According to the 2010 Nursing Drug Handbook,	F 332		

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F 332	Continued From page 60 this medication is to be given after meals with plenty of water to minimize GI (gastro intestinal) upset. R18 had not eaten dinner prior to receiving this medication. 2. On 9/8/10 from 8:15am to 8:4am, surveyor observed E5 (nurse) pass medications to R5. One of the 8 tablets given was Potassium chloride 20 meq (millequivalents) by mouth. The directions on the medication card indicates, "take with plenty of water." E5 gave R5 four ounces of water to take all 8 tablets. The plastic cups the staff uses during medication pass are 4 ounces. According to the 2010 Nursing Drug Handbook, under patient teaching reads: "tell patient to take with or after meals with full glass of water or fruit juice to lessen GI distress. The Medication Administration Policy indicates the following: II. Administration of Medications * Medications must be administered in accordance with a physician's order, e.g., the right resident, right medication, right dosage, right route and right time.	F 332		
F 356	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name.	F 356		10/15/10

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F 356	Continued From page 61 o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to prominently display for residents, families and visitors, the posing regarding nurse staffing data. This deficient practice had the potential to affect all the facility's 80 residents. Findings include:	F 356		

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F 356	Continued From page 62 On 9/08/2010 at 11:50am, the surveyor entered the reception area of the facility. This is the area where some residents and all visitors enters the facility. The surveyor observed posted directing across the receptionist desk, the facility's staffing numbers. The date of the posting was written as 9/07/2010. The surveyor asked the receptionist at the desk, what date is it today. The receptionist replied 9/08/2010.	F 356		
F 363	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to serve the correct portion for a fruit servings for 55 of 55 residents on a general diet or regular texture diet. Findings include: On 09/07/2010 between 5:20pm and 5:55pm, the surveyor observed residents receiving the dinner meal in the Unit 1 and Unit 2 main dinning areas. The surveyor noted that resident with order for a regular texture or general diets received a half orange for fruit serving. According to the planned menu a fruit serving of plum was to be served for a dessert and to meet the fruit/ vegetable	F 363		10/15/10

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F 363	Continued From page 63 requirement for menu planning. At 6pm, the surveyor questioned E14 (food service supervisor) about the lack of a whole fruit serving of the fresh orange. E14 told the surveyor, the orange could not fit into the bowl.	F 363		
F 406	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure 4 of 16 residents inside the sample (R5, R6, R13, R14) and 1 supplementary resident (R27) who have a SMI (serious mental illness) diagnosis and a history of inappropriate behaviors receive mental health rehabilitative services, coordinate services with an outside resource provider and adequately address the residents' refusal of specialized rehabilitative services. Findings include: 1. R14 is a 53 year old resident with diagnoses including bipolar disorder. R14 has documented	F 406		10/15/10

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F 406	Continued From page 64 history of explosive and aggressive verbal behavior toward staff and other residents. The social services notes and nurse's notes document the following: -1/6/10: R14 refuses to come to some structured activities because he says the noise level upsets him. when he does participate, he is very passive. The quarterly review indicates R14 at times is isolative, withdrawn , has difficulty in expressing himself, can be resistant to care by refusing to eat his meals, experiences low frustration tolerance and will become verbally abusive to staff and clients. -1/18/10: R14 was witnessed as having a physical altercation with another resident in a wheelchair. 14 was frustrated that he cold not get the other resident to move out of his way and pushed his wheelchair into the other resident. As R14 was being redirected he became frustrated and left. -4/7/10: E9 (social service) visited R14 to discuss recent escalation in anxiety regarding the condition of the bathroom on his wing or the way in which the bathroom tissue is hung on the roll. R14 has become verbally abusive towards staff stating, "you need a new position because you are ignorant." -4/16/20: (nurses note): was verbally aggressive, likes to degrade other residents -5/10/10: (Client) R14 approached about his failure to attend skills training groups. R14 states, this he has no desire to interact with certain peers	F 406		

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F 406	Continued From page 65 in the group. -6/9/10: Client (R14) approached multiple times about scheduled group meetings, continues to refuse treatment due to lack of motivation. Client verbally stated that group meetings are a waste of his time and he chooses not to interact with certain peers. Client has shown no progress toward care plan objective. -7/13/10: Client has improved socially since last evaluation. He makes anxious complaints regarding others at times due to his inability to cope in new situations. He has continually refused to attend skills training classes. -7/23/10 (nurse's note): resident has been refusing to take his Lithium, states he does not need it. Lab called, Lithium level critical low. MD (medical doctor) paged. This information was endorsed to the next shift. However there is no documentation to show if the MD answered the page or how this concern was addressed. -8/11/10: Behavior: Client states that he is having difficulties with other residents. He states they are speaking to him in a "negative way, i.e.. cursing at him" or that another resident has rammed his wheelchair when in fact the incident was an accident. -8/16/10: (nurse's note) Write was rendering medical services to another male resident when when resident (R14) came to nursing station demanding that I make the other resident leave so that he could receive something for pain. Writer then explained to him that once I was	F 406		

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F 406	Continued From page 66 done, I would take care of him. Resident (R14) then became upset and angry and said he called 911 and told them he was being threatened. Writer asked why he called the police, R14 stated, "I wanted him away from the desk so I could get some medication." R14 was redirected to his room. -9/2/10: Client has made several complaints towards a peer. He has began to antagonize hie peer and then makes comments to the staff the "he is threatening me". the client is experiencing increased agitation in the last few days. 1:27pm: Writer, administrator, fellow peer and client meet today to discuss an ongoing conflict between them. The client stated, "his very presence irritates me" within the meeting and began to call his peer a "cotton picker" and stated, "I want to provoke him in order for him to hit me and he will be sent out." His doctor will be contacted. On 9/2/10, R14 was sent out to the hospital for a psychological evaluation. R14 has constantly informed staff that he does not want to participate in group skills training. It has been identified that R14 does not like or do well in a group setting. The facility has not shown evidence of a documented plan for development of a behavior modification program or what was done to decrease incidents of inappropriate behavior by R14 or how R14 will be encouraged and rewarded for consistently participating in 1:1 programing. 2. R27 is a 55 year old resident with a history of	F 406		

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alcohol abuse and diagnosis of Schizophrenia. According to an incident report. On 1/05/2010 at 10:20pm, R27 returned to the facility from a community pass, a bloody face. He stated he fell three times. R27 was noted with the smell of alcohol on his breath. R27 was sent out to the ER (emergency room) and returned after receiving 5 sutures above his left eyebrow. There was no investigation beyond the resident's statement. No confirmation on the use of alcohol. No intervention regarding inappropriate behavior while on pass. The intervention included counseled on alcohol abuse. The resident's care plan during the time period does not reflect the resident was in a rehabilitative program addressing alcohol abuse with mental illness.

On 9/14/2010 at 4:15pm, the surveyor interviewed E9's (social service director) about the intervention taken post R27's 2/02/2010 incident. E9 stated R27 still has a community pass privileged. Now he is on a level two, where he can go out with a staff member or a family member. The surveyor asked about the program R27 was attending. R27 was not listed among the residents attending the outside MISA (mental illness substance abuse) program, offered by the facility. E9 told the surveyor R27 was evaluated last Thursday (9/09/20100 and would attend by tomorrow (9/15/2010).

3. R13 is a 55 year old resident with a diagnosis of psychosis due to substance abuse and mental illness. On 9/09/2010 at 4:18pm, R13 confirmed he attends any day program.

According to the facility's list of residents attending a substance abuse program for the

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F 406	Continued From page 68 mental illness, R13 is not listed. On 9/09/2010 at 11:10am E9 (social service director) reported E9 communicates with R13's day program via phone or fax about the day to day issues. The surveyor asked about the specific identified problems the day program was currently working with R13 to achieve. E9 began reading varies not measurable goals for the resident. The surveyor asked what programs or interventions the facility is doing to help R13 meet the goals? E9 initially stated R13 was attending a skills training program, but later stated he was not, because he had a head trauma. In addition, E9 stated, R13 had graduated from the MISA group provided by the outside provider, and longer attending the program. The surveyor asked how does the facility monitor R13 for possible relapse? E9 stated, if substance abusive behavior is suspected, then a urine/blood screening is done. R13's comprehensive care plan dated 6/28/2010 had an identified problem with substance abuse. The goal for this problem, is the resident will comply with intake procedures for a substance abuse treatment and increased group attendance . The resident's attendance to the day program/behavior center was added on 9/09/2010 after the surveyor's concerns were identified. 4. R6 is a 54 years old resident. R6 has a diagnosis of schizoaffective disorder, depression and alcohol dependence. On 9/07/2010 between 2:40pm and 3:30pm the surveyor observed ambulating from outside the building through out Unit 1. R6 was listed to attended the facility in	F 406		

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F 406	Continued From page 69 house psychosocial skill program. On 9/07/2020 at 2:40pm, the surveyor interviewed R6. R6 stated he desire to leave the facility and go to a shelter care facility. R6 told the surveyor he is not attending any type of group activities. When the surveyor asked about the attendance to the MISA (mental ill substance abuse) group, R6 stated he was not going to stop drinking (alcohol). As a response to the surveyor observations of R6 not attended listed psychosocial groups, the facility presented the following: -social service documentation dated 7/06/2010 of R6's refusal of complying with mental health rehabilitative program. -statements of resident's right to refuse skill training dated: 8/03, 8/10, and 8/20 /2010: signed by R6. However, R6's comprehensive care plan did not address these refusal. In addition, E9(social service director) did not present any evidence this resident was referred to the psychiatrist or psychologist for further interventions. 5. R5 is a 74 year old paroled resident, admitted to the facility on 11/25/2009. R5 has a diagnosis of depression and has an order for Lorazepam 0.5mg (milligram) every 4 hours as needed for agitation. On 9/07 and 9/08/2010 during the morning and afternoon hours, the surveyor noted R5 in the room without staff or resident interactions. The surveyor on 9/07/2010 at 12:30pm, noted R5 eating in the room alone without any stimulant to	F 406		

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F 406	Continued From page 70 the environment. For example, the use of a radio or television playing. R5 stated he prefers not to attend group activities. Prefers TV watching in room. R5 commented what could a 74 years old male do. When surveyor asked about regular meetings with facility's staff. Resident stated 2 weeks ago he met with E9, but nothing on a regular basis. R5 expressed his desire to live in a less restricted environmental since, he believe he could be more independent. On 9/09/2010 at 4:38pm, the surveyor was presented with information from E1 (administrator). This was related to questions and concerned not answered by E9 earlier. The documents received included: -A comprehensive care plan dated 12/01/2010 noting R5 isolative behavior and refusal with the goal of resident to meet with social service as tolerated. - Social service progress note dated 9/09/2010 discussing the resident's desire for discharge to another facility. -1 statement dated 7/13/2010 regarding R5's right to refuse skills training. The evidenced presented does not demonstrate the facility investigating R5's refusal for services and any adjusting or changing interventions to address R5's refusal. E9(social service director) did not present any evidence this resident was referred to the psychiatrist or psychologist for further interventions.	F 406		
F 469	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest	F 469		10/15/10

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F 469	Continued From page 71 control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: During lunch observation on 09/07/10 at 12:30 pm, Surveyor observed R4 was eating her lunch the feeder table. Surveyor observed fly and gnats (small black flying insects) flying around the dining room. R4 was eating lunch Surveyor observed fly was landing on the table. R4 was observed eating chopped ham several fly was landing on the fork. Surveyor observed a staff member E20 (Certified Nurse Aide) was observed sitting at the feeding table with another resident. E20 did nothing to keep fly and net from flying on the food of R4. Based on observation, record review and interview the facility failed to maintain an effective pest control program so that the facility is free of pests and flying insects in 2 of 2 Units and 3 of 3 dining rooms and other common areas where residents live. This failure has the potential to affect all 80 residents who reside in the facility. Findings include: 1. On 9/7/10 during the lunch meal observation from 11:55am - 12:20pm the following was observed: -in the Sun Porch Dining room several flies and small, black flying insects were noted flying around residents and their food trays. Several	F 469		

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F 469	Continued From page 72 residents including R2 and R10 were noted shooing flies away from their lunch. -At 12:30pm, In the larger dining room on Unit II, several flies and small black flying insects were noted flying around several residents including R9,R33, R35, R36, R37, R38, R39, R40 and R41 meal tray and landing either on the plate, cup or saucer as well as the tables. -During lunch observation on 09/07/10 at 12:30 pm, Surveyor observed R4 eating her lunch at the feeder table. Surveyor observed flies and small black flying insects flying around the dining room. As R4 was eating her lunch, flies wer landing on the table as well as R4's fork while she was eating chopped ham. R4 did not shoo the flies away. At the time of this observation, E20 (Certified Nurse Aide/CNA) was observed sitting at the feeding table with R38. E20 did not shoo the flies or the small black flying insects away fro the resident's food or the table. The Health Care Service Tickets of the Pest Control company dated March 2010 through September 2010 indicate for the September 3rd visit no fly relief bag. In Building I, inspected flies (house) inspected at walk through. Activity sighted. Tech did fly program to help reduce activity. *Please keep dumpster lids closed. 2. 9/07/2010 between 9:15am and 10:15am, the surveyor conducted an initial tour accompanied by E18 (quality assurance nurse). The following observations were made:	F 469		

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F 469	Continued From page 73 -Flies in the cooridor between rooms 110 and 113. -Torn window screen in the boiler room. -Unit 2's women bathroom, 5 spiders with spider's webs near toilet areas and ceilings. 3 adult ants, 1 of 3 with wings in and near tub area. The Health Care Service Tickets of the Pest Control company dated February 2010 through September 2010 indicate various areas in the facility were treat for ant activity and prevention	F 469		
F 520	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		10/15/10

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F 520	Continued From page 74 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to have a quality assessment and assurance system that utilizes the in put of the medical director and identify causes, patterns and trends regarding repeated residents falls and put into place corrective actions, methods to monitor the effectiveness of corrective action and revise corrective actions to minimize the risks for additional falls and serious injuries. This deficient practice affected 7 of 16 sampled residents (R3, R4, R5, R6, R12, R13, R14) and 7 supplementary residents (R17, R20, R21, R22, R23, R24, and R27) who experience falls. R5, R13 and R17 had an injury as a result of the fall. The facility's ineffectiveness to implement corrective changes for fall prevention for the residents, was identified as an immediate jeopardy on 9/13/2010. Findings include: On 9/09/2010 and 9/13/2010, the surveyor conducted interviews with 4 of 10 (E1/administrator, E2/director of nurses, E9/social service director and E14/dietary manager) members of the facility's quality assurance committee members. Each member identified a past identified problem resolved by the committee, as falls. The direct care staff members were given in-services regarding the committee's recommendations. All the member's when asked about the attendance of the Medical Director, answered he was not present at the last meeting.	F 520		

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F 520	Continued From page 75 Additional interviews with E17 (nurse), on 9/09/2010 at 12:18pm review this staff was aware of the use of the fall identification program by the committee. On 9/13/2010 at 10:30am, E2 (DON) was questioned further about the committee's methods for determining problems. E2 told the surveyor, the committee noted the number of falls residents were having. Such as multiple falls and the use of helmet. The committee set-up an identification for the people at risk for fall. At first the use of a leaf, post at the door or a bed side. The surveyor asked, what problem was to be corrected. E2 did not answer the questioned. On 9/13/2010 at 3:20pm meeting with E1 and E3 present at the time, the surveyor asked E1, What was the role of the medical director? E1 replied, the medical director read over the QA committee's minutes. The surveyor asked if the medical director was present during the discussion of falls. E1 replied, No. E1 told the surveyor she was the person in charge of the QA committee's meetings. During the survey the surveyor found evidence to support the facility's failure to prevent multiple falls, thoroughly investigated the reasons for falls and review the effectiveness of inventions for the following residents: 1.) On 9/07/2010 at 12:30pm, R5 reported he had recent falls in the facility. R5 claimed he fell in the men's shower room, while the floor was wet. R5 told the surveyor the floor in the shower room is wet all the time. R5 hurt his left leg and it swelled up and just recently went down to normal.	F 520		

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F 520	Continued From page 76 The incidents reports had three incidents involving R5 as follows: -3/08/2010 at 5:45pm, resident observed on floor, in the room. Resident was ambulating at the time. R5 stated he attempted to turn off the light and lost his balance. R5 fell onto the floor on his buttock. Intervention taken: Body check/assessment done immediately-no injuries noted. MD (medical doctor) notified of incident-new orders received. Family notified. Safety re-eduction done, . -3/09/2010 at 7:20pm, resident observed on floor, in the room. Noted with hematoma to left side of head. Apparently lost balance and hit head in process. Intervention taken: body check/assessment done immediately, neuro check performed immediately and resident sent to emergency room(ER) for medical evaluation. -3/12/2010 at 5am in the bathroom, Patient stated that he bumped his left leg into the metal demarcation (unknown object) in the residents bathroom. Patient has two open areas on the left left and the area appear swollen. Intervention taken for prevention: First aid given. Railings checked by maintenance in Unit 1 bedroom. No rough edges noted. Safety teachings reinforced. None of the facility's investigations for the above incidents address the cause of R5's fall and injury. The investigation did not go beyond the resident's statement to the staff. The care plan did not reflect any adjustment in the resident's monitor or supervision. Also no care plan intervention were changed. On 9/09/2010 at 11am, the surveyor asked E2	F 520		

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F 520	Continued From page 77 (director of nurse) in the presence of E3 (nurse consultant), why type of safety education was given to R5 after the fall on 3/08 and 3/12/2010? E2 was unable to tell the surveyor. 2.) On 9/07/2010 one of the surveyor approached R13 to inquire about a bandage attached to his head. R13 told the surveyor he fell, while outside. According to R13 record, R13 had a history of left hip fracture, and seizure disorder The computerized incident report dated 9/01/2010, documented R13 had a fall incident at 9am on 9/01/2010, while outside. R13 was in a chair (wheelchair) at the time. R13 was noted to have a laceration to the left forehead, and transferred to the ER. The incident was not witnessed by any staff member. The hospital emergency room record, stated R13 had a head injury. "The skull and/or brain were affected." The investigations conducted by the facility consist of R13`s statement at the time of the incident. According to one part of the investigation. The wheelchair was locked during the incident. R13 leaned and fell out the chair. Another part of the documented investigation, documented R13 stated that he was in the wheel chair when the rubber part of the small wheel came completely off. Wheelchair leaned side way and resident had fall. On 9/09/2010 at 4:18pm, the surveyor met with R13 to discuss the incident. R13 told the surveyor	F 520		

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he was being pushed by another resident, going across the street. While being push over pot holes and bumps one of the wheels rubber came off. The chair tilt, he leaned and fell to the ground. E12 (director of maintenance) was in R13's room at the time, R13 told the surveyor E12 replaced the wheel. E12 confirmed he replaced the wheel on R13's wheelchair.

The surveyor reviewed R13's care plan's dated 8/10/2010 had added to the goal of resident will not sustain a fall-related injury the following interventions, 9/01/2010 resident will inform staff regarding any repairs needed to wheelchair. Encourage resident to allow staff to assist with cleaning and maintenance of wheelchair. Encourage resident to ask for assistance. None of these intervention address how R13's wheelchair became in disrepair, nor what regular maintenance including monitoring the staff will do to prevent it from happening again.

3.) R17 is is a 51 year old resident with diagnoses including dizziness and orthostatic hypertension.

Review of the Incident Accident log for 2010 shows R17 had 2 fall incidents.
On 3/9/10 while ambulating in the dining room, R17 lost her balance and fell. R17 complained of pain to her left ankle.
On 3/10/10 R17 was noted with bruising to the left ankle. R17 was sent to the hospital for evaluation and returned in the evening with a diagnosis of fracture of left fibula. R17 required a leg cast.

On 6/18/10 a 6:15am, R17 slipped in the shower.

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F 520	Continued From page 79 R17 complained of lower back pain. An Xray ordered for the lumbar spine was negative for fractures. On 9/13/10 E2 (director of nursing) stated, "she (R17) entered the shower area without supervision. The staff didn't know she was in the shower." The quarterly MDS (minimum data set) dated 8/17/10 shows R17 scored 2 in cognitive skills for daily decision making which indicates moderately impaired - decisions poor; cues/supervision required. In walking and personal hygiene/bathing, R17 scored 1/2 which indicates supervision/setup help only. On 9/14/10 at 2:10pm, R17 was interviewed in her room. Surveyor asked R17 had she had any falls within the last 6 months. R17 stated, "I fell in the dining room in March. I broke my ankle. I just slipped. I got the cast off April 27th. About 3 months ago, I felt dizzy and I slipped in the shower. No one was in there. I managed to get up and I told staff. I didn't bump my head but I did hurt my back. It was sore for a while." R17 was not noted wearing a orange wrist band during the time of this interview. 4.) R27 is a 55 year old resident with a history of alcohol abuse and diagnosis of Schizophrenia. According to an incident report. On 1/05/2010 at 10:20pm, R27 returned to the facility from a community pass, a bloody face. He stated he fell three times. R27 was noted with the smell of alcohol on his breath. R27 was sent out to the ER and returned after receiving 5 sutures above his	F 520		

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F 520	Continued From page 80	F 520		

left eyebrow. There was no investigation beyond the resident's statement. No confirmation on the use of alcohol. No intervention regarding inappropriate behavior while on pass. The intervention included counseled on alcohol abuse. The resident's care plan during the time period does not reflect the resident was in a rehabilitative program addressing alcohol abuse with mental illness.

On 9/14/2010 at 4:15pm, the surveyor interviewed E9's (social service director) about the intervention taken post R27's 2/02/2010 incident. E9 stated R27 still has a community pass privileged. Now he is on a level two, where he can go out with a staff member or a family member. The surveyor asked about the program R27 was attending. R27 was not listed among the residents attending the outside MISA (mental illness substance abuse) program, offered by the facility. E9 told the surveyor R27 was evaluated last Thursday (9/09/20100 and would attend by tomorrow (9/15/2010).

The facility's resident behavior management and outside pass program stated the inappropriate and unacceptable behaviors including but not limited to : using non-prescribed drugs or alcohol: will result in immediate pass suspension.

5.) R23 has diagnosis of cerebral palsy and grand-mal seizures. R23 had the following fall incidents:
-1/22/2010 at 4:34pm, computerized documented fall at 1pm, in the corridor. R23 was wearing slippers. However, the hand written incident report documented 1/22/2010 at 8:45am, the fall incident in the corridor.

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F 520	Continued From page 81 -1/22/2010 at 3:20pm, hand written fell by nursing station. The intervention was increase supervision. No investigation to determine any one of the record falls. -1/29/2010 at 9:30am in the television room. Resident was observed laying on the floor on the right side. Intervention use of chair alarm when out of bed and pad alarm while in bed. -2/18/2010 at 3:45pm, unwitnessed fall by staff. However, another resident told staff resident started to get up and fell backward and hit his head. The incident took place in the dayroom. No investigation of the cause nor the factor surrounding the fall was noted. No change in the care plan interventions. No documentation of the use of the chair alarm and going off to alert staff members of R23's movement. -8/12/2010 at 9:59pm, computerized documented a fall on 8/12/2010 at 6:30pm, in the hall. R23 sustained a bruise noted to the right side lower back. R23 observed getting up from a chair and ambulated pass the nursing station and fell. No change in the care plan interventions. No documentation of the use of the chair alarm and going off to alert staff members of R23's movement and staff intervention at the time. The surveyor did not see any evidence of the interdisciplinary team to review this resident's care plan to determine how effective any of the previous intervention to prevent R23 from fall a fifth time. R23's care plan had multiple dates from 4/06/2009, 7/03/09, 9/28/09. 12/09, 3/28 and 6/20/2010. The care plan was not reviewed at the time of R23's falls. According to the facility's policy for fall prevention program: The care plan incorporates addressing each fall and interventions are changed with each	F 520		

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F 520	Continued From page 82 fall, as appropriate. Immediate change in interventions that were unsuccessful. This was not implemented for R23. 6.) On 9/07/2010 between 10am and 2:40pm the surveyor observed R6 ambulating outside the facility's building in the park lot and sitting areas. On 8/07/2010 at 2:40pm, interviewed the resident in the lounge located in Unit 1. R6 had a orange wrist band on one of wrist. R6 told the surveyor he was in a shelter care facility prior to his admission to the facility three years old. R6 told the surveyor he was hit by a car and woke up at the facility. On 9/08/2010 at 9:40am, 11:20am, and 3:35pm, R6 was observed ambulating outside the facility around the front of the building and park lot area. R6 was not engage in any activity with any resident and no staff was present in the area. On 9/09/2010 during an interview with E2 (director of nurses), the surveyor was told that the leaf on any resident's room door or head of bed and the present of an orange wrist band; meant that resident was high risk for floor. This was initiated in July 2010. R6 had the following computerize incident report with accompanying investigation: -4/24/2010 10:14pm, Fall incident at 4:45pm, outside. Observed on ground by peer, who notified staff. - 05/07/2010 12:50pm, Fall incident date 4/24/2010 at 10:14pm. The resident was located outside the facility at the time. R6 reported he	F 520		

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F 520	Continued From page 83 tripped. The surveyor could not determined if these two dates were two separated reported fall incident or the same one. On 9/09/2010 the surveyor questioned E2 (director of nurses) since she filled out and signed the staff interview post accident/incident sheet dated 4/24/2010. E2 confirmed the documentation above both refer to the incident on 4/24/2010 and it occurred at 4:45pm, but charted at 10:14pm. The management follow up to incident had no investigation beyond the incident report. There is no interview of the witness, a peer. There was no investigation done to determine the cause and/or the factors that cause R6 go fall. The intervention was to monitor on unit and grounds. This intervention was not observed implemented on 9/07 and 9/08/2010, while R6 ambulated outside without visual supervision from staff. 7.) R12 is a 53 year old resident admitted to the facility on 7/28/2010. R12 has diagnosis including but not limited to dementia and seizures disorder. R12 had a physician order initially dated 7/28/2010 for chair alarm, when up in chair for safety. The surveyor did not note any discontinue orders for this chair alarm in place up to the current physician' order for September 2010. On 9/07/2010 at 4:35pm, R12 was positioned in a geriatric chair in the Unit 2 television viewing area. R12 was placed in the lowest reclining position of the chair. E19 (certified nurse aide)	F 520		

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F 520	Continued From page 84 who was in the area at the time, told the surveyor R12 was in the chair like that, because he tries to get up. On 9/09/2010 at 10:46am, the surveyor observed R12 in the Unit 2's television viewing area, in the geriatric chair. R12 was making several attempts to sit up in the chair. R12 told the surveyor he wanted to sit up. On 9/09/2010 at 12:00pm, E20 (nurse aide) who was taking care of R12, was questioned about the use of a chair alarm. E20 stated she was not aware of the use of an alarm. E20 told the surveyor she had taken care of R12 before this day. R12 had the following documented fall incidents: -7/29/2010 at 10:27pm, unwitnessed in room, resident was found on the floor. Protective device in use: pad alarm secondary to risk for fall. The investigation consist of the resident's statement: He was getting out of bed to go to the bathroom. Interventions stated put in place: assessed for injury and pain. Redirected to use call light for assistance and not try to get out of bed by himself. Pad alarm in place. Orange band/leaf to identify risk for falls. -Computerize incident 8/17/2010 documented 7:41am, at 4:30am while making rounds, resident observed on floor. Resident in a sitting position. Resident stated he was trying to got to toilet without assistance. Interventions stated put in place:assessed for injury and pain. Redirected to use call light for assistance and not try to get out of bed by himself. Pad alarm in place. Orange band/leaf to identify risk for falls.	F 520		

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F 520	Continued From page 85 Both investigations had the same information. No change in any interventions. Nothing about staff member being alerted to the pad alarm, if it was applied. Nothing about toileting the resident. During the survey, the surveyor noted the use of incontinent pads/briefs in use for R12. The facility's policy for fall prevention program stated: Residents at risk of falling will be assisted with toileting needs in accordance with voiding patterns identified during the assessment process and as addressed on the plan of care. This was not implemented for R12. Care plan dated 8/02/2010 had problem with poor balance and goal to be free from a fall related injury and problem of history of seizure and goal of not experience any injury from seizure activity through 11/02/2010. No falls were noted as a problem in the the care plan. 8.) -R14 is a 53 year old resident with diagnoses including bipolar disorder, EPS tremors (extrapyramidal syndrome) and left leg cellulitis. R14 uses a wheel chair to move throughout the facility. The incident summary dated 8/30/10 indicates R14 reported to staff he was trying to transfer himself from his bed to his wheelchair when he fell onto his buttocks. This was a unwitnessed fall. The quarterly MDS dated 7/5/10 The quarterly MDS (minimum data set) dated 8/17/10 shows R14 scored 2 in cognitive skills for daily decision making which indicates moderately impaired -	F 520		

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F 520	Continued From page 86 decisions poor; cues/supervision required. In transfer and in walking, R14 scored 2/2 which indicates limited assistance/one person physical assist. 9.) R4 was observed on 09/7/10 at 11:30 am sitting in chair dining room. Resident is alert and answer simple question. R4 was a 89 year old female with diagnosis Hypothyroidism, Alzheimer, Pacemaker, Insomnia Expressive Aphasia, Frontal Sinusitis, Orthostatic Hypertension, Cardio Syncope and Sinuitis. The Minimum Data Sets dated 04/20/10 and 06/18/10 denoted : Section B: (4). Cognitive Skill for Daily Decisions-Making was score 2 moderate impaired - decision poor, cues/supervision required. Section J (4). Accidents fells in [past 30 days and fell in past 31 - 180 days. The fall incident and accident report denoted: 04/07/10 at 5:00 pm Call by resident that patient (R4) fell. Pt was walking around. Resident fell in Television room on knee. 04/20/10 at 9:50 am fell in dinning room. She was ambulating. Alert and disoriented normal for resident. Pupil response, pupils equal and reactive to light equal. Move all extremities. Blood pressure 198/132. Physician notified Z7 ordered received transfer to nearest emergency room. Resident noted with high blood pressure, lethargic, no apparent injury noted. 05/09/10 2:45 pm Resident observed on floor in dining room on unit 2. Resident unable to explain. No witness to fall. Re-educate on importance of	F 520		

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F 520	Continued From page 87 waiting for assist from staff. 08/08/10 1:22 pm Fall observed on floor in television area. Resident was observed sitting on couch in television room. Resident was lying on side on floor. Resident fell and hit her head on the floor. Vital sign taken and transferred to emergency room. She will be going to Z1 hospital. Alert but confused. The fall risk assessment dated 04/20/10 at 1:30 pm denoted Resident is not at risk for falls. There was no assessment or reassessment for resident after each fall. The fall care plan intervention and approaches was not updated or revised to prevent resident from further fall. 10.) R3 was observed on 09/07/10 at 10:15 am in the dining room. She was sitting in a wheelchair. She was also observed with right hand tremor/shaking continual. R3 was alert but unable to answer question. R3 has diagnosis Hypertension, Senile Dementia with Delusional Features, Seizure, Hypothyroid and Schizo Affective Disease. The Minimum Data Sets dated 07/29/10 denoted: Section B. (4). Cognitive Skills For Daily Decision-Making was score 2 - moderately impaired - decisions poor, cues/supervision required. The fall accident report denoted: 06/2410 at 8:40 am - R35 came out of her room and said that R3 was on the floor. So, myself (E22) and E2 (Director of Nurse) and one of the hospice aides went to the room to check it out and then we all picked her up off the floor.	F 520		

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F 520	Continued From page 88 Resident was last seen in her room which she rolled herself to her room. Continue review of the fall accident report denoted that the following dates 04/25/20 and 07/26/20 their was no investigation completed. There was assessment or reassessment of the above fall incidents. The fall care plan intervention and approaches was not updated or revised to prevent resident from further falls. 11.) R20 with a history of a stroke had the following fall incidents: -2/06/2010 at 7am, observed resident in sitting position in bathroom. Interventions instructed to wear shoes at all time. No investigation of why R20 fell and how the fact of having no shoes, contributed to the fall. -computerized documentation 6/24/2010 at 8:30am, a fall in the bathroom. However, the written investigation stated resident was found of floor, in the hallway. There was no investigation to determine why the resident fell and no change intervention. 12.) R21 has a diagnosis of dementia with behavior disturbance and a history of seizure. R21 had the following fall incidents: -3/21/2010 at 4:39am computerize documented fall incident 3/21/2010 at 2:00am. R21 was walking without shoes on on the side walk of building. No investigation and no change in interventions. Post fall R21 instructed on safe use	F 520		

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F 520	Continued From page 89 of assistive device. Safe transfer techniques. Use of call light . Resident exited back door and exit alarm sound. The report documented R21 was alert but confused. Cognitively impaired Unable to interview. -3/22/2010 9:45pm, resident found in room on floor. The investigation did not go beyond the incident report. The intervention were Complete body assessment. Safety teaching reinforced. Matt at bedside. Bed in lowest position. Medication for agitation as needed Increase superversion when resident is anxious or agitated state. Medication review by DON(director of nurses). No conclusion to the investigation. No indication R21 had a behavior before the fall. -On 4/07/2010 at 10:43pm, computerized documented fall 4/07/2010 at 3:45pm in the resident's room. Resident found on flooring on her stomach. Intervention -reeducated to safety issues. Staff to initiated every 15 minute checks, after R21's return to the facility. The reason for R21's fall was not investigated for proper care planning of interventions. -On 7/03/2010 at 2:51pm, computerized documented fall 7/03/2010 at 1pm, Resident found on the floor, in room. Resident sent out to hospital. Resident was alert-disoriented. Resident was last seen propelling self through out facility in her wheelchair. Intervention included the use of a pad alarm to wheelchair. The surveyor did not see any evidence of the interdisciplinary team to review this resident's care plan to determine how effective any of the previous intervention to prevent R21 from fall a fourth time. The care plan was not reviewed at the time of R21's falls. The care plan reviews were at 3/21, 3/22, 4/07 and 6/10/2010.	F 520		

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F 520	Continued From page 90 According to the facility's policy for fall prevention program: The care plan incorporates addressing each fall and interventions are changed with each fall, as appropriate. Immediate change in interventions that were unsuccessful. This was not implemented for R21. 13.) R22 has a diagnosis of a stroke and mental retardation with an unsteady gait. R22's minimum data set dated 2/14/2010 indicated R22 had a fall within the past 30 days. Incidents reports and fall investigations documented the following: -3/16/2010 at 6:40pm, unwitnessed fall in the dining area on the floor. Resident called for help. The investigation does not include any cause or possible factors contributing to R22's fall. -4/01/2010 at 9:12pm, computerized fall documented a fall on 4/01/2010 at 4:15pm while in the dining room. Resident found lying on left side. The investigation does not include any cause or possible factors contributing to R22's fall. R22's 3/06, 6/16/2010 care plan reviews had no change in interventions. On 9/07/2010 at 10:15am, initial tour of the facility, the surveyor observed the dining area in questioned was located directly across the unit's nurse station. According to the facility's policy for fall prevention program: The care plan incorporates addressing each fall and interventions are changed with each fall, as appropriate. Immediate change in interventions that were unsuccessful. This was not implemented for R22. 14.) On review of the facility's incident reports the surveyor noted the following concerning R24:	F 520		

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F 520	Continued From page 91 -6/21/2010 at 9:55am, computerized documented fall on 6/21/2010 at 9am, resident had a fall outside the facility. Resident sustained a brusing/skin tear. Resident stated she slipped when she was rising from chair. The resident reported the fall to the nurse. First aid was applied to right elbow and right knee. The intervention was that resident would let staff know her where about. No investigation surrounding the fall was done.	F 520		