STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145668	A. BUILDING _____ B. WING _____	05/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HOME, THE	150 NORTH 27TH STREET BELLEVILLE, IL 62226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure/Recertification Survey. FOSS Survey. An extended survey was conducted.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY 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 the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide privacy during care for two (R1 and R8) of 21 sampled resident, and two (R30 and R42) off sampled residents. Findings include: 1. On 5/12/06, at 4:31 PM, E24, Registered Nurse was passing medications to residents of the 400 hall. At this time R30 was sitting in a wheel chair, in the 400 hall across from the nurses station . E24 asked R30 if she could do R30's accu-check. E24 did the accu-check on R30's right mid finger, and when she obtained a high result, E24 gave R30 an injection of insulin in her left upper arm. Additionally, E24 offered R30 her Flovent inhaler as part of the med pass as R30 sat in the hall. E24 did not offer or ask R30 if she wanted privacy for these procedures. A review of the facility policy for "Insulin Injection Administration Procedures" indicated the following: "Note: Blood glucose monitoring - wash hands before and after procedure, provide privacy.". 2. On 5/13/09, from 2:00 PM to 3:00 PM, E7, Treatment Nurse, and E23, Licensured Practical Nurse was changing R8's pressure ulcer dressings to his heels and buttocks. The curtain between the bed was only partially closed , due to nursing staff moving back and forth from the dressing cart at the foot of the bed to R8's bedside. At 2:48 PM, E41, Certified Nurses Aide, opened the door to the room and stepped inside. E41, stopped suddenly, looked at the staff standing in the room, then knocked on the door, and stated "I just wanted to put bed pads on the	F 164		

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F 164	Continued From page 2 beds". E41 , then placed a pad on the bed closest to the door and left the room. No other information was given as to why E41 did not protect R8's privacy by knocking on the door prior to entering the room. 3. On 5/13/09 at 9:28am, E6, CNA, turned R1 over for a skin check exposing her coccyx area and her entire right side from her waist to her feet to her room mate who was sitting on the other side of the room facing R1's bed. No curtain was pulled prior to pulling back R1's blanket. 4. On 5/13/09, at 11:22 AM, the door to Room 114 was closed. The surveyor knocked, E20, Certified Nurse's Assistant (CNA), responded "Come in". R42 was lying on his back in his bed. R42 was naked from the waist down. R42's privacy curtain was drawn to prevent his roommate from seeing him; however, R42's privacy curtain was not drawn in manner to prevent him from being exposed to the doorway.	F 164		
F 221 SS=G	483.13(a) 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 identify a medical need and assess the risks versus benefits for the	F 221		

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F 221	Continued From page 3 use of restraints for five (R4,R9,R15,R18 and R24) of five sampled residents with restraints. This failure resulted in R9 falling to the floor with his wheelchair and soft waist restraint attached to him. R9 sustained a laceration to his nose. He was sent to the hospital and received sutures. The finding include: 1. R9's physician's order sheet, dated May 2009, documents he has partial diagnoses of Anxiety and Alzheimer's Disease. The facility's Incident Report, dated 3/20/09, at 6:00 AM, noted he was found on the floor with a wheelchair on top of him with a soft belt still intact. He had a laceration to his nose. He was sent to the hospital and received sutures to his nose. The Recommendation/Interventions listed "will place front and back anti tippers on w/c (wheelchair)". R9's care plan, dated 3/20/09, noted "Res has a soft self release waist restraint. Res had hx (history) of falls. Has had no falls since soft restraint." The approaches documented "Staff to release soft waist restraint during meals and when in full view of staff". R9's care plan was not updated to address the fall, on 3/20/09, or the restraint. R9's Quarterly Restraint Effectiveness Report, dated 12/20/08, noted the reason for the use of the soft waist physical restraint was "falls-unaware of his own safety". There was no documentation on this report regarding if any attempts had been made to use a less restrictive measures or R9's response to those measures. This report did not indicate the risks versus benefits of using a soft waist restraint. Furthermore, this report did not indicate the medical need for the restraint. After R9 fell on	F 221		

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F 221	Continued From page 4 3/20/09, the facility did not reassess the appropriateness of the soft waist restraint or the risks versus benefits of using this restraint. On 5/12/09, at 10:28 AM, R9 was in a geriatric recliner with a soft waist restraint in the therapy room. E21, Licensed Practical Nurse, noted he was in the geriatric recliner due to he was Hospice and had experienced a decline in condition. On 5/12/09, at 11:35 AM, R9 was in the main dining room in the geriatric recliner with the soft waist restraint. Staff fed R9 his lunch and he remained in the dining room until 1:30 PM, at which time he was placed in his room. At no time, did the staff remove R9's waist restraint during the meal. On 5/13/09, at 8:34 AM, E10, Certified Nurse's Aide (CNA), was feeding R9. R9 remained reclined in his geriatric chair with his soft belt restraint throughout the meal. On 5/14/09, at 9:13 AM, E22, Certified Nurse's Aide noted "Sometimes he (R9) slides down in his chair and we have to pull him up. When he was in his wheelchair, he would try to get up. Sometimes we would see him trying to make his bed. He doesn't do that anymore, he has had a decline." The facility did not reassess for the appropriateness of the soft waist restraint after R9 was placed in the geriatric chair. 2. R18 was admitted on 4/8/09. R18's physician's order sheet, dated May 2009, noted she had a right hip fracture. R18's nurse's note, dated 5/11/09, at 4:00 PM, documented "To residents room after hearing personal alarm. She had moved herself to end of bed and was attempting to get over side rail into wc (wheelchair). Did not use call light. 'I	F 221		

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F 221	Continued From page 5 can do this myself'. Alarm secured. Resident witnessed moving alarm. Redirected. " R18 currently has a low air loss mattress due to Stage III and Stage II pressure ulcers on her buttocks. The manufactures recommendation for this type of bed indicate the use of full side rails for safety. On 5/14/09, at 4:25 PM, R18 was lying in her bed. She had full side rails up on both sides of the bed. Again, at 10:03 AM, and again at 10:50 AM, R18 was lying in bed with full side rails up on each side of the bed. R18's Minimum Data Set, dated 4/21/09, noted she had "other types of side rails used (e.g. half rail, one side)". Her interim care plan, dated 4/8/09, had not been updated to address the use of the siderails or her attempts to crawl out of bed with the side rails up. R18's Side Rail Assessment, dated 4/8/09, noted she had right and left side rails to serve as an enable to promote independence. The assessment indicated there was no risk to R18 if the side rails were used, although she has attempted to climb out of bed twice. Furthermore, the assessment documented the side rail/alternatives/interventions did not create more risks than side rail use. R18's full side rails for the risks versus benefits of their use after she attempted to climb out of the bed. The facility did not reassess the risks versus benefits of using a mattress which requires the use of full side rails while R18 is in bed. 3. R24's record was reviewed as a closed record. R24's original admission date was 2/25/09. R24's Physician's Order Sheet for April 2009 listed partial diagnoses of Renal Insufficiency, Anemia, Failure to Thrive, Urinary Tract Infection, Cataracts, Hypertension; Cerebral Vascular Accident.	F 221		

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F 221	Continued From page 6 R24's initial siderail assessment is dated 2/25/09. The assessment is incomplete, with some questions not answered. The questions "Does the resident have a history of falls, Is there evidence the resident has or may have a desire or reason to get out of bed?" are both blank. The questions: "Is there a risk to the resident if siderails are used?" is answered NO. There is no risk versus benefits assessment listing the potential risks of using siderails for R24. R24's accident/incident reports and investigations documented skin tears of unknown origins on 3/4/09, 3/10/09, 4/10/09, 4/27/09, and 4/29/09. On 4/6/09 at 12:30 AM, R24 was discovered to have bruising of his right upper arm and chest, near the axilla. Nursing notes documented a dark purple bruise 7 - 8 centimeters round. X-ray of right ribs obtained on 4/8/09 documented lower lobe infiltrate and old healed fracture of the eighth rib. R24 had a large bruise to his right neck and shoulder, origin unknown, on 4/9/09. There is no re-assessment of the siderails to determine if the siderails could have caused the skin tears or bruises. The assessment failed to inform of potential risks of injury caused by use of siderails. 4. R15's Physician's order sheet dated 5/1/09 indicated a diagnoses in part of; Neurogenic Dysphagia, Hemiplegia, and Parotis Left Face. On 5/13/09 the physicians order sheet indicated R15 should have 1/2 side rails on her bed. The most recent Minimum Data Set dated 4/20/09, indicated R15 has modified independence for decision making, is an assist of one staff for transfers, and needs staff assistance for all activities of daily living. Intermittent observations throughout the days	F 221		

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F 221	Continued From page 7 of 5/12/09, 5/13/09 and 5/14/09 indicated that when R15 was in bed with full siderails up on each side of R15's bed. A review of R15's side rail assessment dated 4/13/09, indicated R15 could get out of bed safely, and used the siderails for positioning and support. The assessment indicated R15 did not ask for the side rails. The side rail assessment also indicated that Physical Therapy and Occupational Therapy was asked to consult on the use of the side rails. The side rail assessment failed to indicate any safety and risks involved if R15's was to use of them. The assessment did not address R15's use of full side rails. On 5/14/09 at 9:40 AM, E31, Certified Occupational Therapy Aide, stated that she was not aware of any request for R15's side rails to be assessed by therapy. E31 indicated that siderails were a nursing issue and that therapy usually did not evaluate siderail use, unless for a resident's special needs. On 5/15/09, at 11:30 AM, E2, Director of Nursing, stated that upon R15's last admission, 4/13/09, she was put into a bed that had full side rails on it already from a previous resident. E2 stated R15 should only have "1/2 size" siderails on her bed, and that to keep the full side rails on her bed since admission, had been a mistake of the facility. 5. R4's Physician's order sheet dated 5/1/09 indicated a diagnoses in part of Pulmonary Edema, Left Hip Fracture, Right leg prosthesis, and Admitted with open area to stump. The most recent Minimum Data Set, dated 2/11/09, indicated R4 was alert and oriented, and was a minimal assist of one staff for transfers and activities of daily living. A recent care plan entry	F 221		

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F 221	Continued From page 8 dated 3/18/09 indicated " resident will occasionally refuse to allow side rails to be pulled up. Will have no falls or serious injury related to refusal to use side rails. Staff to encourage resident to allow 1/2 side rail to be raised to assist him with bed mobility". R4's most recent side rail assessment, not dated or signed, was incomplete It indicated that R4 did not request siderails, R4 could get in and out of bed safely, and the 1/2 side rails were recommended for bed mobility. R4's side rail assessment failed to indicate the safety and risk issues involved with their use, and failed to offer alternative devices for the resident to use in bed, as he was documented as resistive to the rails being up.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS 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. 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	F 225		

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F 225	Continued From page 9 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 observation, interview, and record review the facility failed to investigate and report to the Department, an allegation of possible physical abuse for one (R8) resident in the sample of 21 . Findings include: 1. On 5/13/08, a review of R8's physician's order sheet indicated he has a diagnoses in part of; quadriplegia, chronic pain, and multiple chronic decubitus ulcers. On 5/14/09, at 10:20 AM, R8 stated " about 3 or 4 months ago I got into an argument with E27, Licensed Practical Nurse (former employee). E27 and I were yelling at each other and she grabbed me by the arm and held it. Other staff saw it and reported it to the Administrator, and later she (E27) was fired".	F 225		

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F 225	Continued From page 10 On 5/14/08 at 11:10 AM, E1, Administrator, was interviewed regarding the above information given by R8. E1, stated that she would look for the incident report. On 5/15/08, and 5/19/08, E1 was again asked for the incident report for R8. E1, stated that she was looking for it, but was not sure where it was filed as she was not administrator when this incident happened to R8. On 5/20/08, at 8:45 AM, R8 stated that he had discussed the incident with E1 the day after it had happened. R8 stated "The CNA's working in the hall saw it happen and told E1. E1 came down here and talked to me privately to be sure that I was okay and not still upset about what happened, and after that E27 was fired. On 5/20/08 at 11:30AM, E1 stated that she did not file an incident report or report the incident between R8 and E27 to the Department. E1 stated R8 had cursed at E27, and E27 had grabbed his arm in order to get his attention and try to get him to stop cursing. E1 stated E27 did not mean it as abuse. E1 stated she had not filed an incident report because R8 had been cursing at E27, and R8 had not been hurt in the altercation. E1 also stated that she did fire E27 after talking with R8, because of other problems in her work performance in addition to E27's "rough handling" of R8. The facility Abuse Policy indicated " Once the administrator determines that there is a reasonable cause for possible mistreatment, the administrator or designee will appoint a person to take charge of the investigation. If, during the course of an incident investigation, the administrator of designee has determined that there is reasonable cause to suspect mistreatment has occurred, the resident's representative and the Department of Public Health shall be informed immediately".	F 225		

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F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS 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 on observation, interview, and record review the facility failed to follow it's policies to investigate an allegation of abuse for one (R8) resident in the sample of 21 . Findings include: 1. On 5/13/08, a review of R8's physician's order sheet indicated he has a diagnoses in part of; quadriplegia, chronic pain, and multiple chronic decubitus ulcers. On 5/14/09 at 10:20 AM, R8 stated " about 3 or 4 months ago I got into an argument with E27, Licensed Practical Nurse / former employee. E27 and I were yelling at each other and she grabbed me by the arm and shook it. Other staff saw it and reported it to the administrator, and later she (E27) was fired". On 5/14/08 at 11:10 AM, E1, Administrator, was interviewed regarding the above information given by R8. E1, stated that she would look for the incident report. On 5/15/08, and 5/19/08, E1 was again asked for the incident report for R8. E1, stated that she was looking for it, but was not sure where it was filed as she was not administrator when this incident happened to R8. On 5/20/08, at 8:45 AM, R8 stated that he had discussed the incident with E1 the day after it had happened. R8 stated "The CNA's who saw it happen told E1. E1 came down here and talked	F 226		

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F 226	Continued From page 12 to me privately to be sure that I was okay and not still upset about what happened, and after that E27 was fired. On 5/20/08 at 11:30AM, E1 stated that she did not file an incident report or report to the Department the incident between R8 and E27. E1 stated R8 had cursed at E27, and E27 had grabbed his arm in order to get his attention and try to get him to stop yelling. E1 stated E27 did not mean it as abuse. E1 stated she did not file an incident report because R8 had been cursing at E27, and R8 had not been hurt in the altercation. E1 also stated that she did fire E27 after talking with R8, because of other problems in E27's work performance and her "rough handling" of R8. The facility Abuse Policy indicated " Once the administrator determines that there is a reasonable cause for possible mistreatment, the administrator or designee will appoint a person to take charge of the investigation. If during the course of an incident investigation the administrator has determined that there is a reasonable cause to suspect mistreatment has occurred, the resident's representative and Department of Public Health shall be informed immediately.".	F 226		
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents do	F 241		

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F 241	Continued From page 13 not have to sit for extended time before receiving their food for four (R5,R9,R16 and R17) and two expanded sampled residents (R42 and R45) during two meal observations; and failed to promote dignity of one (R31) expanded sampled exposing herself; and failed to promote dignity by maintaining clothing in good condition for two (R8 and R15) of 21 sampled residents. 1. During noon meal on 5-12-09, R16, R17 and R42 were observed to be sitting at the Dining Room table at 11:45AM with no fluids or food. R45 was also at the table with her daughter, who was providing her fluids while she waited for her tray. R16 was taken from the Dining Room at 12:45PM, by E1, Administrator. R16 did not receive any food or fluids. E1 stated she was taking R16 to her room because her back hurts and she doesn't want to eat. At 12:59, R17 received her tray. R42 was observed to be sleeping in his wheel chair and was not served his meal until 1:01PM. R45 was served at 12:50PM. R45's daughter stated it was not unusual for the residents at the table to wait for a long time to get their trays. During meal observation, on 5-13-09, R16 was observed to be sitting at the Dining Room table at 11:50AM with no food or fluids. R16 did not receive any food or fluids until 12:26PM. On 5-13-09, R17 was observed sitting at the Dining Room table at 11:59AM and did not receive her tray until 12:30PM. Record review of R16 and R17's most current Minimum Data Set, MDS assessment, shows they are totally dependent on staff for eating.	F 241		

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2. On 5/12/09, at 11:37 AM, R5 was in the main dining room. At 12:00 PM, his two tablemates received their meals. R5 sat at the table while these residents ate their meals. At 12:20 PM, R5 received his lunch meal and began to eat.

3. On 5/12/09, at 11:35 AM, R9 was sitting in the main dining room waiting for his lunch. R9 had no fluids to drink. Lunch service began at 11:45 PM. While R9 waiting for his lunch, the majority of the residents in the dining room received their lunch and ate. R9 received his meal at 12:53 PM. .

4. On 5/12/09, at 10:34 AM, R31 was sitting in a wheel chair in the center activities area, next to the door way of the social services / nursing department. R31 was rolling her hands inside her shirt, causing the shirt to rise up and expose both her breasts. There were multiple residents in the area, and at least five staff were moving back and forth through out the room attending to other residents, or going in and out of the nursing offices.

At 10:37 AM, R31 continued to expose herself, as staff and residents moved about in the room. A female resident sitting next to R31 stated to another resident, "look at her (R31) she must be confused."

At 10:39 AM, a female staff member who was in the activities room was informed of R31's behavior, pulled R31's shirt down, and took R31 to her room to find a shirt that better covered her.

On 5/20/07, at 9:00 AM, E2, Director of Nurses, indicated that R31's behavior was not usual for her; however, no information as to why

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F 241	Continued From page 15 the multiple staff walking by R31 on the morning of 5/12, failed to notice her exposing herself for at least 5 minutes. 5. On 5/13/08, a review of R8's physician's order sheet indicated he has a diagnoses in part of; quadriplegia, chronic pain, and multiple chronic decubitus ulcers. The most recent care plan dated 4/2/09 indicated R8 requires assistance for all Activities of Daily Living. On 5/14/09 at 8:45 AM, E38 and E39, both Certified Nurses Assistants (CNA), dressed R8 for the day. E38 and E39 dressed R8 in a pair of grey sweat pants which had brown stains on the legs, and were ripped at the waist band. Also, R8 was dressed in a faded grey/green sweat shirt which was frayed around the collar and cuffs. On 5/14/09 at 10:20 AM, R8 stated he was aware his clothes were frayed. he noted his pants had torn when staff lifted him and used his pants for leverage. E8 stated he was only bothered a little to wear these clothes, especially if he had to leave the building for a doctors appointment. E8 stated no staff had offered to replace his pants, or had suggested calling his family to see about having some of his worn clothing replaced. On 5/19/09 at 10:45AM E26, Social Service Director, stated that R8 was alert and could ask his family for clothes if he wanted them. E26 stated she had seen R8 wearing the torn clothing, but had not directly asked R8 if he was okay with wearing clothing with holes and stains on them. E26 stated she had not thought to suggest to R8 to have the clothing replaced, nor had she offered to assist R8 to get the clothing replaced.	F 241		

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F 241	Continued From page 16 6. Throughout the day of 5/12/09, R15 was seen either lying in bed or in her wheel chair with a white thermal blanket covering her legs and torso. The blanket was frayed and worn in several areas with a large tear at the hem. At 2:26 PM, E18, Certified Nurse's Aide, assisted R15 to bed from her wheel chair, and covered R15 with the same torn white blanket. At one point E18 picked the blanket up and upon seeing the rip at the hem, E18 shook her head and said "Oh my gosh!". E18 then folded the blanket putting the torn hem on the bottom side but leaving the frayed areas exposed, and covered E18 with the blanket. No information was given as to why no staff took the time to replace the blanket with one in better condition.	F 241		
F 246 SS=E	483.15(e)(1) ACCOMMODATION OF NEEDS 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 by: Based on observation, record review, and interview; the facility failed to answer call lights timely and have call lights accessible for two (R1, R2); failed to accommodate resident preferences for awakening and bedtime for six (R5, R47, R48, R49, R50, R52); failed to wake one (R32) resident up in time to eat breakfast in the dining room; failed to offer showers regularly for one (R33), failed to serve meals timely to numerous dependent residents while other residents were	F 246		

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F 246	Continued From page 17 eating; failed to remove soiled meal trays timely for one (R7); failed to provide appropriate resident equipment for one (R1, R13) of 24 sampled residents and seven off-sample residents. Findings include: 1. During the Group Interview on 5/13/09, nine of the ten residents attending the interview stated that the night shift routinely wakes the residents around 4:30 AM. R52 stated that staff woke her at 4:30 AM, helped her get dressed, then sat her in her wheelchair until breakfast was served. R47, R48, R49, R50 verified that residents were awakened between 4:30 and 5 AM. The residents expressed concern for the total care people having to sit up so long prior to breakfast meal service. 2. R2 was interviewed on 5/12/09 at 2:30 PM. R2 has a gastrostomy tube feeding that is hooked up during the night. R2 stated that he frequently hears the alarm on the tube feeding pump go off during the night time feeding. R2 stated he no longer puts on his call light to inform the nurse because, "It doesn't do any good. They never answer the call lights." 3. Record review of R33's Minimum Data Set, MDS of 4-4-09 shows she has no cognitive impairment and she requires extensive assistance with bathing. R33 stated on 5-12-09 at 1:10PM, she is not getting showers as she is suppose to. R33 stated staff will tell her they are too busy and the next shift will assist her with a shower and it does not happen. R33 stated she is suppose to get a shower on Mondays and Thursdays. She said	F 246		

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last Thursday staff told her they were too busy. R33 stated she complained so much that they finally gave her a shower at 10PM on Saturday night. R33 stated she was afraid she would be the only dirty mother on Mother's Day. R26, R33's roommate stated, "It's the truth."

4. On 5-19-09, at 8:55AM, R32 was observed to be in bed. R32 stated he wanted to wash his hands and eat breakfast in the Dining Room. R32 stated he did not want to stay in bed. E12, Certified Nurse Aid,CNA, stated he was not out of bed because the night shift did not get him up. E12 stated R32 will not be eating in the Dining Room. R32's tray was at bedside. R32 stated he didn't want it. They can throw that in the hall way. "There is no excuse for this."

Record review of R32's MDS of 4-10-09 shows he is extensive assistance for transfers and hygiene and requires tray set up only.

5. Record review of R7's MDS of 5-10-09 shows she requires 1 person, limited assistance with eating.

R7 was observed on 5-12-09 and 5-13-09 to eat lunch meal in bed. On 5-12-09 at 12 noon E12, CNA, was observed to bring in R7's lunch tray and set up her food. At 12:20PM, R7 stated she was finished eating, the food was good but she was full. At 1:50PM, the tray of uneaten food was still sitting on the over bed table in front of R7. At 12:13PM, R7's lunch tray was still there.

R7 was observed on 12-13-09 to again eat her meal in her room. R7 was in bed and eating at 11:55AM. R7's tray remained in her room on the over bed table above her bed until 1:30PM, when her daughter was visiting.

6. Review of the MDS dated 3/24/09 identifies R13 as being an 80 year old female readmitted to

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F 246	Continued From page 19 the facility on 3/28/08 with diagnoses of Nephritis, Hemiplegia, Hematuria and Hypertension among others. The MDS indicates R13 has short/long term memory deficits with moderate cognitive impairment and requires extensive assist of staff for most activities of daily living. (normal 8-20). On 5/12/09 at 1:12pm, R13 was in her room at the foot of her bed in her wheelchair. Her water pitcher was sitting on her bedside nightstand in the corner. R13 also did not have her call light within reach. R13 was observed at 1:25pm, 1:30pm, 1:35pm and 1:40pm to remain at bedside in her wheelchair with no fluids or call light within reach. At 2:10pm, R13 was transferred to bed by E6, CNA. R13's feet were noted to extend past the end of the bed. Her feet were elevated on pillows but her toes and feet hung over the end of the bed. R13 stated she was 6 foot tall and acknowledged that the bed was short. R13 also stated on 5/15/09 that she does use her call light at times. 7. Review of the MDS dated 3/10/09 identifies R1 as being a 79 year old female readmitted to the facility on 8/12/08 with diagnoses of Decubitus Ulcer of lower back among others. The MDS indicates R1 has short/long term memory deficits with severe cognitive impairment and totally dependent on staff for all activities of daily living. The clinical record identifies R1 to have severe contractures of both hands. R1 was noted to have a regular call light system which was not observed within reach during any time of the survey. There is no indication the facility provided an appropriate call light appliance that R1 could use with her contractures. On 5/15/09, E1, Administrator was asked about any special call light devices, that would enable R1 to use a call light and E1 stated she was unaware that the	F 246		

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F 246	Continued From page 20 facility had such devices. The facility failed to accommodate R1's call light needs given her inability to use a regular light. 8. On 5/12/09, at 2:30 PM, and again on 5/14/09, at 9:30 AM, R5 noted there was no enough staff in the facility. R5 noted there was never enough staff on the night shift. He indicated staff wake him at 4:00 AM for breakfast due to the staffs inability to get everyone up for breakfast. R5 indicated he does not sleep well and this is really early for him. 9. On 5/13/08, a review of R8's physician's order sheet indicated he has a diagnoses in part of; quadriplegia, chronic pain, and multiple chronic decubitus ulcers. The most recent care plan dated 4/2/09 indicated R8 requires assistance for all Activities of Daily Living. On 5/13/09 R8 stated that many times he has to wait up to 45 minutes for staff to answer his call light. R8 stated that this happens on all shifts and more on weekends. R8 indicated there are numerous times staff forget to give him the call light. R8 is quadriplegic and cannot get it for himself. R8 indicated he is in the last room on the hall, and would prefer to be closer to the nurses station due to his limited ability to get help once he is in his room and in bed. R8 stated when staff forget to give him his call light, he is forced to yell for help until someone hears him and comes to see what he wants.	F 246		
F 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility staff failed to assess and provide meaningful activities for four (R2,R3,R6 and R11) of 21 sampled residents and one (R32) expanded sampled resident.

Findings include:

1. R6's physician's order sheet, dated May 2009, noted he had the following partial diagnoses: Dementia and General Weakness.
R6's Minimum Data Set (MDS), dated 2/3/09, noted he attended some activities.
R6's Activity Assessment and Plan, updated and reviewed on 11/3/08, indicated was interested in music, religious activities, wheeling outdoors, social events and parties, puzzles, writing/reading, television and radio. According to the assessment, R6 preferred activities in his room.
On 5/12/09, at 11:30 AM, R6 was lying in his bed asleep. His privacy curtain was pulled around him. At 12:25 PM, he was located in the dining room eating lunch. From 1:30 PM until 2:30 PM, R6 was in bed with his privacy curtain pulled around him. Throughout this time, R6 was not seen partaking in any activities or provided any stimulation or activities in his room.
On 5/13/09, R6 was either in bed or up for meals. He did not attend any activities. Although R6 enjoys television, the television was not on in his room.
On 5/14/09, R6's care plan, dated 5/8/08, was the only care plan available in his medical record. This care plan did not address his activity interest

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F 248	Continued From page 22 or interventions to address his activity needs. The facility provided a copy of a care plan on 5/19/09 which addressed his activity needs. 2. Record review of R32's Minimum Data Set, MDS, of 4-10-09 reflect he participates in activities 1/3 to 2/3's of the time. MDS shows he likes spiritual/religious activities. R32 was observed on 5-12-09 during tour of the facility, to ask staff why they did not come and get him to go to mass. R32 was upset and stated they knew he wants to go to mass. On 5-21-09, R32 stated he often misses mass because no one takes him. 3. Record review of R11's MDS of 3-29-09 reflects she is involved in activities 1/3 to 2/3's of the time. MDS shows R11 is totally dependent on staff for care. Record review of R11's Care Plan of 3-5-09 shows there is no Care Plan that addresses activities for R11. R11 was observed to remain in bed during the Survey except for meals and Therapy. On 5-12-09 at 5PM, R11 was in bed with the TV on. R11 she wasn't watching the TV because nothing good was on. R11 stated she liked watching TV when there was something on that she likes. R11 said she liked watching the news. 4. R2 is 56 years old with partial diagnoses, from Cumulative Diagnosis Sheet (undated) of: Suicide Attempt, Wound - Mouth, Major Depressive Disorder, Tracheostomy. During a Resident Interview with R2 on 5/12/09, at 2:30 PM, R2 stated, "It's boring around here for me. There are no activities of interest to me. I just go outside and stand around	F 248		

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F 248	Continued From page 23 where they smoke, just to get some fresh air. Mostly, I lay around in my room." R2's current care plan is dated 12/23/08, with update on 3/20/09. R2's care plan does not address activities for R2. R2's Resident Assessment Protocol dated 12/17/08 did not trigger activities as a problem area. 5. R3 is 79 years old with diagnoses (from May 2009 Physician's Order Sheet) of: Alzheimer's, Increased Confusion, Hypertension, Debility unspecified. R3's current MDS is dated 3/20/09. He is assessed as totally dependent on staff for bed mobility, transfer, dressing, eating, hygiene, bathing, toilet use. R3's current care plan updated on 3/19/09 stated that R3 is "unable to assist staff.....minimal to extensive assist...Unable to make needs known r/t dementia..." R3 was observed frequently throughout the survey from 5/12/09 through 5/19/09. On 5/12/09, at 11:35 AM, 11:55 AM, 2:15 AM, 2:40 AM - R23 remained in his bed. There was no television or radio on in the room. On 5/13/09, R3 was observed at 8:35 AM, during a dressing change. At 9:25 AM, he was on his right side, facing the door. At 2:10 PM, he was seated in a geriatric recliner new to his bed. There was no television or radio on in the room. R3's Care Plan dated 12/26/08 with update on 3/19/09 was reviewed. There was no problem identified in the Care Plan to address R3's need for activities on the Care Plan on R3's active chart. The facility provided information on 5/19/09 stating that R3 is on 1:1 activities. The information stated that R3 was visited by the Activities Department 5 times a week. R3's daily	F 248		

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F 248	Continued From page 24 participation documentation had an activity noted on 5/7/09 and one on 5/11/09. A "revised", back-dated care plan dated 3/19/09 was presented by the facility. This "revised" care plan stated R3 has decreased socialization and stimulation related to being in bed most of the time related to multiple wounds.	F 248		
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES 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 observation, interview, and record review the facility failed follow it's policies to provide sufficient social services to meet the needs of two (R8, R21) residents in the sample of 21. Findings include: 1. R8's physician's order sheet dated 5/1/09 indicated R8 was admitted on 1/11/08 with a diagnoses in part of Quadriplegia, Super-pubic Catheter, Chronic Pain, Chronic Urinary Tract Infections. The most recent Minimum Data Assessment (MDS), dated 4/2/09, indicated R8 had persistent anger with self and others, repetitive health complaints, and repetitive anxious complaints and concerns / attention seeking. The MDS indicated that R8 had no behavior issues. However, The MDS did indicate that R8 had conflicts with / and / repeated criticism of staff, and did not readily change	F 250		

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routines.

On 5/12/09 at 1:00 PM, E25, Licensed Practical Nurse, described R8 as a very difficult resident, wants to have his way, or will refuse treatments, and necessary care.

On 5/13/09 at 1:00 PM, Z1, Registered Nurse / Wound Management Nurse, stated she had started working with R8 in February 2009. Z1 stated R8's refusal to cooperate with staff had contributed to R8 developing new pressure areas on his heels. Z1 indicated some of her time is spent intervening in the conflicts between R8 and staff in order to get R8 to cooperate to aide in healing R8's multiple pressure ulcers, and allow him to have some control over his care.

On 5/14/09 at 2:00 PM, E21, Licensed Practical Nurse stated R8 was a resident that was very demanding of staff, and had a history of becoming upset and yelling at staff if they did not provide services as he thought should be done.

On 5/14/09 R8 stated care given by facility staff was "adequate". E8 stated staff left him without a call light at times, forcing him to yell for help, and that staff did not always follow the schedule set up by Z1, to turn and reposition him. E8 stated he did argue with staff, especially when he felt treated / talked to as if he was old and demented. R8 stated that at times he felt staff did not care about him as a person, and at times were were rushing to do their jobs. Most recently, on 4/1/09, R8 and a female nurse were in an argument, when the nurse grabbed and firmly held R8's arm in order to try and get him to stop talking.

A review of the 1/11/08 initial Behavior Symptom Evaluation (BSE)was completed by E26, Social Service Director, indicated R8 was depressed, with persistent anger, Health and anxious complaints. E26 indicated R26 was

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young and depressed with placement in the facility. E26 wrote "res has individualized care plan and tracking in place." On 4/11/08 a BSE reassessment was done by E26 which indicated that R8 was still having complaints and still with a diagnosis of depression.

A quarterly behavior assessment , dated 7/19/08, indicated R8 had reasonable judgement, appeared adjusted, communicates without displaying difficult behaviors symptoms, is moderately dependent and a fair candidate for discharge. Quarterly social service notes done between 11/2008 and 4/3/09 indicate R8 has behavior tracking.

The nursing care plan dated 4/2/09 indicated R8 takes Amitriptyline 25mg at bedtime for a diagnosis of depression.

The most recent social service care plan dated 5/1/09 indicated R8 displays behaviors of health and non-health complaints. Resident angry with self and others do to placement in facility. R8 has diagnosis of depression and is currently taking Lorazepam for symptoms. Per resident 1:1, social services will explain care and allow resident to vent concerns, encourage activities, praise efforts, and redirect if resident becomes agitated. R8 will decrease complaints to one time per week.

On 5/15/09 E26 stated that R8 no longer had depression. E26 stated she had assessed R8 by talking to him, that R8 displayed no "outward" signs of depression, and R8 did not complain of being depressed. E26 noted R8 had not been of Lorazepam for depression for a while, although it was still written on the current care plan.

E26 stated that R8 is very alert and speaks up for himself. E26 stated although she had seen R8 wearing worn / tattered clothing in the facility. E26 stated R8 had not thought to ask if R8 was

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F 250	Continued From page 27 concerned about his clothes. E26 stated she had not asked R8 about them or offered to assist R8 to replace the worn clothes. E26 stated that she did not do routine 1:1's with R8 because she sees him frequently throughout the week due to ongoing complaints by R8 and/or facility staff. E26 stated R8 would agree to care plan goals and then would not always comply with them. E26 explained R8's persistent anger and outbursts as R8 just wanting to have things his way. E26 stated she did not see R8's ongoing resistive behavior / anger outbursts and refusal of care as a need for a more frequent 1:1 or other intervention to help R8 cope. E26 indicated R8 was very verbal and could ask for a 1:1 if he wanted it. A review of the facility policy "Behavior Management Program, NM.I-11" the following was noted: 1) Standard: Residents who display mental or psychosocial adjustment difficulty should receive appropriate services in an attempt to correct the problem. 2) IL: Behavior Management Programs: a) The plan of care should be developed by the interdisciplinary team, based on findings from the RAI assessment. Underlying causes for the behavior should be considered. 3) III: Documentation - c) The social service department may be consulted to assist with interventions; actions are recorded in the social service progress notes. 4d) Problem behaviors should be documented on the Behavior Management Record, form NM.I-1a. The problem behaviors should be documented under target behaviors on the form. The number of those behavior episodes each shift, along with information regarding the intervention used by staff to stop the behavior, and the outcome of that intervention, should be documented.	F 250		

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F 250	Continued From page 28 On 5/20/09 at 10:00 AM both E21, Registered Nurse, and E25, Licensed Practical Nurse, stated that there is no behavior management record being filled out for R8's behaviors. E21 stated that problems with R8 are written in the nursing notes, or reported to social service they arise. A review of the social service notes indicated no notes were documented regarding any of the many 1:1 interventions R26 stated she had with R8 in the last year. 2. R21's physician's order sheet dated 5/1/09 indicates R21 was admitted on 4/24/09. R21 has a diagnoses in part of; Anemia, Renal Failure, and Diabetes Mellitus II. On 5/20/09 at 10:20AM in an interview with R21, he stated he is a dialysis patient. R21 held up his right arm to show the shunt site in the right upper inner arm. R21 stated he left the building for dialysis 3x / week. E21's room had no decor on the walls, no clock, or calendar. E21 stated he needed a clock to keep track of time and his dialysis appointments. E21 stated it would be nice to have a calendar too. A white phone was on E21's night stand. R21 picked it up, stated it did not work, and wondered how to have it fixed. E21 stated he had given "my assistant" $520 to hold a trailer for me to live in after I am discharged. E21 wanted to call his assistant and see if the trailer had been obtained. E21 stated he had no other concerns then laughed and said "I got rid of my concerns a while back when I got rid of my wife and son". E21 stated that his wife had caused him to have high blood pressure and so he had to divorce her. E21 then stated my son died 4 years ago. E21 then repeated at least 2 to 3 more times his concerns that he needed to contact his assistant to find out about his money and trailer.	F 250		

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F 250	Continued From page 29 On 5/20/09 at 11:10 AM, E26-Social Service Director, stated R21 had problems with his dialysis, and was at the facility for rehabilitation due to extreme weakness. E26 indicated R21 lived with his wife and son and had good family support. R21's minister and minister's wife had been out to see R21. E26 stated she routinely talked to R21, and he would be a good candidate for discharge if transportation to dialysis is set up properly once he returned home to his wife. E26 stated she had not as yet begun to work on discharge planning for R21 as he had not been given a discharge date from physical and occupational therapy. E26 was informed of all of R21's above stated concerns for his room and discharge, and that the room had appeared more cell like than home like. E26 stated that R21 had not mentioned wanting a clock to her. E26 stated had been in R21's room but had not noticed the barren interior. E26 stated I can get him a clock and a calendar, and rose for his table too. E26 stated that is was part of her job to address residents psychosocial needs, but she was not aware of R21 having any at this time. E26 stated she had completed and initial assessment/questionnaire with R21 at admission. E26 stated she was not aware R21 was making plans to leave. E26 then stated "R21 doesn't even have a phone in his room, how can it be broken! I don't know why he told you all of this information, he's never mentioned it to me. On 5/20/09 at 1:00 PM R21 stated that E26 had come and talked to him in his room. R21 stated he had only spoken to her once or twice before, and was not sure what her job was. On 5/20/09 at 1:45 PM E26 stated she had spoken to R21 and found out that he was	F 250		

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F 250	Continued From page 30 divorced, his son was dead, and that he had given money to a friend to get trailer. E26 stated she called R21's friend and found out the the trailer had been secured. Additionally, written statements regarding R21's phone were given stating that (R8?) never had a white phone, but the statements did not address R21's phone concerns.	F 250		
F 258 SS=D	483.15(h)(7) ENVIRONMENT- SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review and interview; the facility failed to address residents' complaints of noise levels. Findings include: During the Group Interview held on 5/13/09 at 10:00 AM, all 9 residents attending the meeting complained about the noise level in the facility. Five of the nine residents stated the Certified Nursing Assistants (CNAs) will yell down the hallway, requesting supplies, "I need a green diaper", or "bring me some towels". All nine residents stated the CNAs were especially loud on the night shift. The residents stated, "It's like we're living in their workplace, not they're working in our home." Several residents described the CNAs as "fighting" with each other, with statements overheard frequently, "That's not my job, they're not my resident". Resident Council Minutes reviewed for the previous year documented frequent complaints	F 258		

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F 258	Continued From page 31 during resident council regarding CNAs yelling in the hallway. During a meeting with the facility on 5/14/09, records of CNA inservices dated 5/13/09 were presented. The subject of the inservices included "yelling down the hallways...."	F 258		
F 272 SS=E	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; 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.	F 272		

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F 272	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess the for the risks versus benefits of restraints for two (R9 and R18) of five sampled residents with restraints; the facility failed to provide accurate assessments regarding pressure ulcers for two (R17 and R22) of 14 sampled residents with pressure ulcers; the facility failed to conduct inital nursing assessments for one (R23) of 24 sampled residents; the facility failed to complete the Resident Assessment Protocol for one (R4) of 24 sampled residents; failed to conduct accurate and on-going assessments for pain management for two (R9 and R18) of eight sampled residents with pain; the facility failed to complete the comprehensive assessment for one (R21) of 24 sampled residents. Findings include: 1. R9's physician's order sheet, dated May 2009, documents he has partial diagnoses of Anxiety and Alzheimer's Disease. The facility's Incident Report, dated 3/20/09, at 6:00 AM, noted he was found on the floor with a wheelchair on top of him with a soft belt still intact. He had a laceration to his nose. He was sent to the hospital and received sutures to his nose. The Recommendation/Interventions listed "will place front and back anti tippers on w/c (wheelchair)". R9's care plan, dated 3/20/09, noted "Res has a soft self release waist restraint. Res had hx (history) of falls. Has had no falls since soft restraint." The approaches documented "Staff to release soft waist restraint during meals and	F 272		

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when in full view of staff". R9's care plan was not updated to address the fall, on 3/20/09, or the restraint.

R9's Quarterly Restraint Effectiveness Report, dated 12/20/08, noted the reason for the use of the soft waist physical restraint was "falls-unaware of his own safety". There was no documentation on this report regarding if any attempts had been made to use a less restrictive measures or R9's response to those measures. This report did not indicate the risks versus benefits of using a soft waist restraint. Furthermore, this report did not indicate the medical need for the restraint. After R9 fell on 3/20/09, the facility did not reassess the appropriateness of the soft waist restraint or the risks versus benefits of using this restraint.

On 5/12/09, at 10:28 AM, R9 was in a geriatric recliner with a soft waist restraint in the therapy room. E21, Licensed Practical Nurse, noted he was in the geriatric recliner due to he was Hospice and had experienced a decline in condition.

On 5/12/09, at 11:35 AM, R9 was in the main dining room in the geriatric recliner with the soft waist restraint. Staff fed R9 his lunch and he remained in the dining room until 1:30 PM, at which time he was placed in his room. At no time, did the staff remove R9's waist restraint during the meal.

On 5/13/09, at 8:34 AM, E10, Certified Nurse's Aide (CNA), was feeding R9. R9 remained reclined in his geriatric chair with his soft belt restraint throughout the meal.

On 5/14/09, at 9:13 AM, E22, Certified Nurse's Aide noted "Sometimes he (R9) slides down in his chair and we have to pull him up. When he was in his wheelchair, he would try to get up. Sometimes we would see him trying to make his

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F 272	Continued From page 34 bed. He doesn't do that anymore, he has had a decline." The facility did not reassess for the appropriateness of the soft waist restraint after R9 was placed in the geriatric chair. 2. R9's physician's order sheet, dated May 2009, indicated he had diagnoses of Hypertension, Alzheimer's Disease and Anxiety. R9 is currently on Hospice due to Failure to Thrive. R9's physician's order, dated 4/17/09, noted he should receive Roxanol, 10 milligrams, every two hours as needed for pain. R9's Minimum Data Set, dated 3/20/09, documented he had no pain. His care plan, updated on 4/17/09, noted "Has signs of generalized pain at times but is unable to tell staff of location related to decreased cognition". The approaches for this problem noted "Assess effectiveness of pain medication. Assess pain characteristics: duration, location, quality". R9's Medication Administration Record (MAR), dated May 2009, noted he received one dose of Roxanol on 5/5, 5/6, 5/7, 5/9, 5/11 and 5/13/09. There is no documentation in R9's medical record indicating how staff are assessing R9's level of pain. The MAR does not indicate the reason the Roxanol was given or R9's response/efficacy of the medication. R9's Control Substance Sign Out Log noted he received four doses of Roxanol on 5/6/09. This log documents he received three doses of Roxanol on 5/8 and two doses of Roxanol on 5/9/09. These doses are not documented on the MAR. On 5/14/09, at 9:13 AM, E22, Certified Nurse's Aide, CNA, noted "He didn't use to be in pain. He says ow when you move him, he says 'Ow' all the time. When he starts doing that, I tell the	F 272		

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F 272	Continued From page 35 nurse. 3. R18 was admitted on 4/8/09. R18's physician's order sheet, dated May 2009, noted she had a right hip fracture. R18's nurse's note, dated 5/11/09, at 4:00 PM, documented "To residents room after hearing personal alarm. She had moved herself to end of bed and was attempting to get over side rail into wc (wheelchair). Did not use call light. 'I can do this myself'. Alarm secured. Resident witnessed moving alarm. Redirected. " R18 currently has a low air loss mattress due to Stage III and Stage II pressure ulcers on her buttocks. The manufactures recommendation for this type of bed indicate the use of full side rails for safety. On 5/14/09, at 4:25 PM, R18 was lying in her bed. She had full side rails up on both sides of the bed. Again, at 10:03 AM, and again at 10:50 AM, R18 was lying in bed with full side rails up on each side of the bed. R18's Minimum Data Set, dated 4/21/09, noted she had "other types of side rails used (e.g. half rail, one side)". R18's Side Rail Assessment, dated 4/8/09, noted she had right and lift side rails to serve as an enable to promote independence. The assessment indicated there was no risk to R18 if the side rails were used, although she has attempted to climb out of bed twice. Furthermore, the assessment documented the side rail/alternatives/interventions did not create more risks than side rail use. R18's full side rails for the risks versus benefits of their use after she attempted to climb out of the bed. The facility did not reassess the risks versus benefits of using a mattress which requires the use of full side rails	F 272		

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F 272	Continued From page 36 while R18 is in bed. 4. R18's physician's order sheet, dated May 2009, indicated she had diagnoses of Fractured Right Hip, Hypertension, Peptic Ulcer , COPD and Congestive Heart Failure. R18's physician's ordered the following pain medications: Tylenol 325 milligrams (mg), take 2 tablets by mouth every four hours as needed; Darvocet-N 100 tablet, take one tablet every four to six hours as needed; and Hydrocodone 5/ 325, one to two tablets, every four to six hours as needed. R18's Pain Assessment, dated 4/8/09, indicated she was having pain in her right hip at a level of 8 (0 being the least amount of pain and 10 being the most excruciating pain). On 5/14/09, at 4:25 PM, R18 was lying in her bed on her back. R18 said "I'm in pain. You know I broke my hip?" R18 indicated she did receive pain medication although she could not recall when she received her last dose. On 5/19/09, at 9:40 AM, during the treatment of her pressure ulcer, R18 indicated to Z1, Consultant Wound Nurse, she has pain in the pressure ulcer when she moves. R18 rated the level of pain at a 5 (0 being the least amount of pain and 10 being the most excruciating). E7, Treatment Nurse, indicated R18 was on a pain medication but she did not recall if it was a routine medication. Z1 noted R18 should receive her pain medication prior to her pressure ulcer treatment. On 5/19/09, R18's Medication Administration Record was reviewed. Each time R18 received her PRN (as needed) pain medication, the staff did not indicate or document the level of pain she was experiencing. Furthermore, the staff documented the following words "helpful", "resting", "asleep", and "relief" when evaluating	F 272		

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F 272	Continued From page 37 the result of the medication. There is no further documentation or assessment to indicate what level of relief was obtained by the medication. Furthermore, the facility did not assess and evaluate if a routine medication would be beneficial. 5. Record review of R17's May 2009, Physician Order Sheet, POS, show R17 is a 67 year old female admitted to the facility on 2-22-09, with a diagnosis, in part, Cardiovascular Accident, CVA, and Scoliosis. POS shows an order a tube feeding of 86 cc's/hour of Glytrol for 18 hours a day, on at 12:30PM off at 6:30AM and an order for a No Concentrated Sweet diet. POS shows an order for treatment of Santyl to coccyx, cover with dry dressing BID, twice a day. R17's BRADEN SCALE--For Predicting Pressure Sore Risk that is undated and unsigned shows R17 scored an 8 which would indicate severe risk for pressure sore development. The assessment failed to identify R17 as getting nutrition from the tube feeding. After the undated assessment was discussed with them, the facility provided a new Braden Scale assessment dated 5-19-09 that shows she scored a 12 which is at high risk for development of pressure sores. 6. R22 was admitted to the facility on 3/27/09. R22's Physician's Order Sheet dated 3/29/09 documented, "Clarification ...Wound Vac to left lower leg wound. Change dressing Q (every) 3 days or PRN.....". R22's Admission Nursing Assessment is dated 3/27/09. The assessment for Skin Condition is not completed. There is no notation in the nursing notes or assessment regarding R22's wound vac, appearance of leg wounds, drainage. There is no weight on the initial nursing assessment.	F 272		

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7. R23's chart was reviewed as a closed record. R23's most recent admission to the facility was on 4/8/09. R23's closed record did not contain an Interim or Initial Care Plan that identified his specific nursing care needs.

R23's initial Nursing Assessment is incomplete. There is no weight or skin condition documented. There is no diet ordered on the initial physician's order sheet. There is no documentation the physician was called to obtain a diet order for R23.

The facility's policy and procedure for admission nursing assessments was reviewed. The policy stated (in part) that admission nursing assessments should include, at a minimum, nursing needs and self-care limitations to determine assistance needed in performing activities of daily living. The standard per policy stated, "Admission Nursing Assessment should be initiated immediately upon admission of a resident.....and completed 24 hours of the admission."

8. On 5/19/08, a review of R21's Admission Face Sheet indicated an admission date of 4/24/09. A review of the Physician's Order Sheet indicated a diagnoses in part of Renal Failure and Pedal Edema. Additionally, R21 is a dialysis patient. Further review of R21's chart failed to indicate the presence of a Minimum Data Assessment(MDS) and a Care Plan.

On 5/19/09 at 9:30AM, E30, Registered Nurse, MDS / Care Plan Coordinator reviewed the MDS information in her computer program and noted that the 14 day MDS had not been initiated.

On 5/20/08 in an interview with E30, Registered Nurse, MDS / Care Plan Coordinator,

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F 272	Continued From page 39 she stated that she had not done the admission MDS assessment. E30 stated that she had been trying to do several jobs at the same time, was overwhelmed, and had not been able to keep up with getting all of R21's information gathered for R21's the MDS and Care Plan. 9. On 5/19/09 a review of R4's 14-day Minimum Daily Assessment (MDS) dated 11/20/08 had no Resident Assessment Protocol (RAP) form. Throughout the survey requests were made to E30, MDS Coordinator, asking if the form had been completed. R4's RAP form was not evident in information given.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		

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F 279	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed develop a comprehensive plan of care to address the needs of residents for one (R21) of 24 sampled residents. Findings include: 1. On 5/19/08, a review of R21's Admission Face Sheet indicated an admission date of 4/24/09. A review of the Physician's Order Sheet indicated a diagnoses in part of Renal Failure and Pedal Edema. Additionally, R21 is a dialysis patient. Further review of R21's chart failed to indicate the presence of a Minimum Data Assessment(MDS) and a Care Plan. On 5/20/08 in an interview with E30, Registered Nurse, MDS / Care Plan Coordinator, she stated that she had not done the 14 day MDS assessment, and subsequently had not done the care plan. E30 stated that she had been trying to do several jobs at the same time, was overwhelmed, and had not been able to keep up with getting all of the information gathered for R21's the MDS and Care Plan.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS 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	F 280		

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F 280	Continued From page 41 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 review and revise care plans to address changes in level of care, and address new physical conditions for 7(R18, R11, R8, R13, R9, R7, R10) of 24 sampled residents. Findings include: 1. R10's current Minimum Data Set (MDS) dated 3/13/09, assessed R10 having short-term memory problems, no long term memory problems; with modified independence in cognitive skills for daily decisions for daily decision making, some difficulty in new situations only. R10's Care Plan is dated 12/20/07, with the most recent update noted on 9/18/08. R10's updated care plan describes that "R10 makes complaints that someone is "out to get her"...Resident is nearly blind and family believes reisdent is paranoid and making false accusations. Resident refused to take any psychotropic meds or mood stabilizers. Res. has repetitive health and non-health complaints."	F 280		

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F 280	Continued From page 42 There was no update following the initiation of Haldol or Prochlorperazine. There was no identification of targetted behaviors. There is no psychiatric diagnoses that justified the use of any antipsychotic medications. R10's current MDS dated 3/13/09, assessed R10 needing supervision and stand-by assist only for transfer. R10 needed limited assistance of one staff for toilet use. R10's fall risk assessment was dated 9/11/08, with no quarterly assessments since September. R10's Care Plan is dated 12/20/07, with the most recent update noted on 9/18/08. R10's most recent fall risk assessment is dated 9/11/08, with a score of 10. Total score of 10 or above represents HIGH RISK. There is no update after 9/11/08. R10's Care Plan in the chart is dated 8/13/07. This care plan is the interim care plan which is present on all resident's charts at the time of admission. There was no specific problem and plan for R10's high risk for falls. There are no progressive interventions for R10 following falls with injury. R10 had two recent falls, on 5/4/09 and 5/5/09, with significant injury to R10. R10 was evaluated and treated in the emergency room, received sutures to lacerations. R10's care plan was not revised following the falls. 2. R8's physician's order sheet dated 5/1/09 indicated R8 was admitted on 1/11/08 with a diagnoses in part of Quadriplegia, Super-pubic Catheter, Chronic Pain, Chronic Urinary Tract Infections. The most recent Minimum Data Assessment (MDS) 4/2/09 indicated R8 had persistent anger with self and others, repetitive	F 280		

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health complaints, and repetitive anxious complaints and concerns / attention seeking. The MDS indicated that R8 had no behavior issues. However, The MDS did indicate that R8 had conflicts with / and / repeated criticism of staff, and did not readily change routines.

The most recent careplan dated 4/2/09 indicated R8 displays behaviors of health and non-health complaints. Resident angry with self and others do to placement in facility. R8 has diagnosis of depression and is currently taking Lorazepam for symptoms. Per resident 1:1, social services will explain care and allow resident to vent concerns, encourage activities, praise efforts, and redirect if resident becomes agitated. R8 will decrease complaints to one time per week.

Multiple staff interviews throughout the survey with E1, Administrator, E2, Director of Nurses, E30, Care Plan Coordinator, E21, Registered Nurse, E25, Licensed Practical Nurse, and E26, Social Service Director, all indicated that R8 displays behaviors of yelling, anger, resistive to care, and poor decision making. Staff indicated R8's resistive behavior had contributed to R8 developing pressure ulcers on his heels. Most recently on 4/1/09 R8 argued with a staff member that grabbed his arm in an attempt to get R8 to quiet down.

A review of R8's careplan of 4/20/08 for the area PSYCH failed to identify these incidents that put R8 at additional risk, and failed to show additional interventions used to assist R8 to cope with his anger.

R8's Care Plan for Pressure Ulcers dated 4/2/09 failed to mention that R8 resists care, resists turning and positioning, and offers no interventions for this behavior.

3. R9's physician's order sheet, dated May 2009,

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noted he had partial diagnoses of Alzheimer's Disease, Anxiety, Dementia and Dehydration. R9 was readmitted to the facility on 4/15/09. The Hospital's Nursing Home Discharge record, dated 4/15/09, noted he had a blister to his right heel. His admission nursing note indicated he had no opened areas upon readmission. Upon admission to the facility, R9 was placed on Hospice for Failure to Thrive.

The facility's Weekly Pressure Ulcer Logs for 4/22 and 4/28/09, had no documentation regarding a blister on R9's right foot.

R9's nurse's note, dated 4/29/09 noted "An opened area to bottom both R (Right) (and) L (Left) sides are reddened and excoriated noted." There was no measurements or monitoring of these areas in R9's medical record.

R9's physician's order, dated 4/29/09, noted he should receive Vitamin C, 500 milligrams (mg), twice daily, a multivitamin daily, wounds should be cleansed daily with normal saline and wound get and cover with a dry dressing daily.

The facility's Weekly Pressure Ulcer Log, dated 5/6/09, noted R9 had acquired a Stage III pressure ulcer on his right ischium measuring 1.0 centimeters (cm) by 1.0 cm 0.3 cm depth. He had also acquired Stage III pressure ulcer to his left ischium measuring 0.7 cm by 1.0 cm by 0.3 cm depth. In addition, he had a Stage II pressure ulcer to his right heel measuring 5.0 cm by 4.0 cm fluid filled blister.

On 5/7/09, R9's physician ordered to cleanse the right and left buttocks with normal saline, apply Santyl (a debriding agent) and cover with a dry dressing twice daily and as needed. In addition, the physician ordered skin prep to R9's right heel twice daily and staff were to float his heels while in bed.

R9's care plan, updated on 4/29/09, noted he

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F 280	Continued From page 45	F 280		

had open areas to his left and right buttocks. The care plan had not been updated to address the pressure ulcer on his heel.

4. R18 was admitted on 4/8/09. R18's physician's order sheet, dated May 2009, noted she had diagnoses of Right Hip Fracture, Hypertension, Peptic Ulcer, COPD, Congestive Heart Failure and Constipation. R18 had no pressure ulcers on admission to the facility.

R18's nurse's note, dated 4/20/09, noted "Res (daughter) informed her of open areas to buttocks and new tx (treatment)". There was no measurement of these areas in R18's medical record.

The facility's treatment record, dated 4/28/09, noted she acquired a Stage III pressure ulcer, on 4/25/09, on her right ischium measuring 3.0 centimeters (cm) by 2.5 cm with 0.3 cm depth with slough. In addition, she acquired a Stage II pressure ulcer, on 4/25/09, on her left ischium measuring 1.5 cm by 1.3 cm with 0.3 cm depth. The physician ordered a treatment of Santyl (a debriding agent) and cover with a dry dressing daily and as needed. Furthermore, staff were to monitor her heels for redness. There was no documentation in R18's medical record indicating these pressure ulcers were unavoidable.

R18's Interim Care Plan, dated 4/8/09, noted she had a surgical wound but did not indicate she had any pressure ulcers. The facility did not update R18's care plan to address her pressure ulcers.

5. R18 was admitted on 4/8/09. R18's physician's order sheet, dated May 2009, noted she had a right hip fracture.

R18's nurse's note, dated 5/11/09, at 4:00 PM, documented "To residents room after

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F 280	Continued From page 46 hearing personal alarm. She had moved herself to end of bed and was attempting to get over side rail into wc (wheelchair). Did not use call light. 'I can do this myself'. Alarm secured. Resident witnessed moving alarm. Redirected. " R18's Minimum Data Set, dated 4/21/09, noted she had "other types of side rails used (e.g. half rail, one side)". Her interim care plan, dated 4/8/09, had not been updated to address the use of the siderails or her attempts to crawl out of bed with the side rails up. 6. Review of the MDS (Minimum Data Set) dated 3/24/09 identifies R13 as being an 80 year old female readmitted to the facility on 3/28/08 with diagnoses of Nephritis, Hemiplegia, Allergy and Hypertension among others. The MDS indicates R13 has short/long term memory deficits with moderate cognitive impairment and requires extensive assist of staff for most activities of daily living. The MDS identifies R13 as having moderate pain daily in her back and other areas. The Physician Order Sheet (POS)0 shows R13 receives Hydrocodone-APAP 5-500 tabs 1 tablet every 8 hours (6am, 2pm, 10pm) and has Tylenol 325mg 2 tabs every 4 hours as needed ordered as well. As of 5/14/09, the care plan dated 12/24/08 in the clinical record did not include a pain management plan with interventions to ensure R13's comfort. On 5/12/09 at 2:10pm, R13 complained of pain and again on 5/13/09 at 1:26pm. The wound care specialist tried Lidocaine prior to her dressing change due to R13's complaint of pain with her right heel pressure ulcer. On 5/15/09 at 10:20am, R13 again complained about lower right leg pain as she rubbed her right leg just	F 280		

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F 280	Continued From page 47 below the knee. On 5/15/09, the care plan coordinator provided a new careplan that included a pain management program. It was dated 12/24/08. The care plan coordinator was asked if she just wrote the care plan and stated she had just pulled the plan off the computer as she had done the assessments previously. There if no evidence the facility developed and/or implemented a pain management plan which was reflected in the care plan until 5/15/09. 7. Record review of R7's May 2009, Physician Order Sheet, POS, shows R7 has an order for a 1500 cc fluid restriction. Record review shows a transfer order of 4-6-09 for a 1500 cc fluid and a low salt diet. A DIET ORDER & COMMUNICATION form dated 5-8-09 states, "Clarification Fluid restriction 1500 cc/day. Nursing allowed 480 cc's." The facility provided a Care Plan of 3-12-09 that does not identify R7's fluid restriction. On 5-18-09, the facility provided a different Care Plan dated 5-10-09 that identifies R7's fluid restriction but under dehydration, states she is on a 1800 cc fluid restriction and under health concerns identifies a 1500cc fluid restriction. 8. Record review of R11's Care Plan of 3-5-09 reflects she has 1/2 side rails up on bed to assist with turning and repositioning and to promote self independence. R11 was observed thorough out the Survey to have full padded side rails on her bed.	F 280		
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS	F 281		

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F 281	Continued From page 48 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed for three (R36, R37, R38) off sampled residents to do accu-checks and administer insulins in a timely manner;the facility failed for one off sampled resident (R35) to ensure that accu-checks were done only at the time specified by the physician; and the facility failed to apply a splint per physician's order for one (R6) of two sampled residents with splints. Findings include: 1. On 5/12/09 at 12:38 PM, E25 LPN, approached R36 who was eating his lunch in the resident dining room. E25 instructed R36 he need to have his blood sugar level checked. E25 did the accu-check and found R36's blood sugar to be 294. E25 then gave R36 Novolog 100 / 8 units in his left abdominal wall, at 12:44 PM. On 5/13/09 at 9:00 AM, E25 stated that on 5/12/09, she should have done the accu-checks before 12:00 PM. E25 stated she should have made sure that all insulins were given by noon and before the resident's started eating. E25 stated she was late getting the accu-checks done as the unit was very busy, and she had trouble getting organized. A review of the facility Medication Administration policy indicated "All medications should be given in the allotted time frame of one hour before medication time pass and one hour after medication time pass". On 5/20/09 at 12:00PM, E2, Director of	F 281		

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F 281	Continued From page 49 Nursing, stated E25 told me yesterday, that R36 had already started eating and I told her to call R36's doctor. E2 stated she was not aware that E25 had already given R36 his insulin, before the doctor was called. No further information was given as to why staff did not follow the facility policy for timely medication pass. 2. On 5/12/09 at 11:38 AM, E25, Licensed Practical Nurse (LPN), stated that she had passed all of her 11:00AM and 12:00 PM medications and had no other medications to pass. On 5/12/09 at 12:04 PM, E25 instructed R35 he needed to have an accu-check done to check his blood sugar. E25 did the accu-check and found R35's blood sugar to be 136. E25 stated R35 did not need any insulin at this time. A review of R35's chart indicated that there were no physician's orders for R35 to have his blood sugar checked at this time. The physician's order sheet dated 5/1/09 indicated R35 was to have his blood sugar checked at 9:00 AM, and 5:00 PM. On 5/12/09, at 1:00 PM, E25 stated she did not feel R35 was having any type of high or low blood sugar problems, she just misread the orders and did the accu-check at the wrong time. 3. On 5/12/09 at 12:08 PM, E25, LPN, went to the resident dining room where R37 was waiting to be served lunch. E25 instructed R37 he needed to have his blood sugar checked. E25 did the accu-check and found R36's blood sugar to be 190. E25 gave R37, Novolog 100 Insulin / 4 units, at 12:13 PM. A review of the physician's order sheet dated 5/1/09 indicated the accu-check was scheduled for 11:00 AM. 4. On 5/12/09 at 12:19 PM, E25, LPN,	F 281		

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F 281	Continued From page 50 approached R38 in the resident dining room, where he was sitting at the table waiting for his dinner. E25 instructed R38 he needed to have his blood sugar level checked. E25 did the accu-check and found R38's blood sugar to be 204. E25 gave R38, Novolog 100 Insulin / 5 units in his right arm at 12:28 PM. A review of the physician's order sheet dated 5/1/09 indicated the accu-check was scheduled for 11:00 AM. 5. On 1/27/09, R6 sustained a fracture to his left 5th metacarpal. On R6's physician's order, dated 4/28/09, noted "There is a Fx (Fracture) of 5th metacarpal c (with) slight displacement and soft tissue swelling. Cont. hand splint two weeks." On 5/12/09, R6 was seen throughout the day without his splint on his left hand. On 5/19/09, at 11:27 AM, E51, Occupation Therapist Aide, noted R6 should wear the hand splint due to the fracture. E51 noted the splint may have been in the wash on 5/12/09.	F 281		
F 286 SS=E	483.20(d) RESIDENT ASSESSMENT - USE A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to have 15 months resident assessments in the clinical record for eleven (R1, R2, R3, R5, R7, R10, R12, R13, R14, R22, R24) of twenty-four sampled residents. Findings include: Records reviewed during the survey from	F 286		

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F 286	Continued From page 51 5/12/09 through 5/21/09 revealed these residents did not have 15 months of resident assesssments available: R1, R2, R3, R5, R7, R10, R12, R13, R14, R22 and R24. E30, Registered Nurse (RN), stated in an interview that she is responsible for Minimum Data Set (MDS), RAP, and Care Plans for all residents. E30 stated that all the information for the RAPs had been entered into the computer, but she had not printed out the MDS, RAPs for review and signatures of the staff who contributed information to the MDS and RAP for the above residents.	F 286		
F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to have an accurately assess and monitor pain management for five (R16,R13,R1,R18 and R9) of 10 sampled residents; the facility failed to follow an order for a fluid restriction for one (R7) of three sampled residents on a fluid restriction; the facility failed to ensure coordination of care for two (R1, and R10) of four sampled residents receiving Hospice; the facility failed to provide coordination of care for one (R21) sampled resident receiving dialysis; the facility failed to provide accurate and individualized interim care plans for four	F 309		

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F 309	Continued From page 52 (R14,R22,R23,R21) of 24 sampled residents. Findings include: 1. Record review of R7's May 2009, Physician Order Sheet, POS, shows R7 is an 80 year old female admitted to the facility on 1-17-06, with a diagnosis, in part, Congestive Heart Failure, CHF. POS, shows R7 has an order for a 1500 cc fluid restriction. Record review shows a Hospital transfer order of 4-6-09 for a 1500 cc fluid restriction, low salt diet. A DIET ORDER & COMMUNICATION form dated 5-8-09 states, "Clarification Fluid restriction 1500 cc/day. Nursing allowed 480 cc's." On 5-15-09, the facility provided a Care Plan of 3-12-09 that does not identify R7's fluid restriction. On 5-18-09, the facility provided a different Care Plan dated 5-10-09 that identifies R7's fluid restriction but under dehydration, states she is on a 1800 cc fluid restriction and under health concerns identifies a 1500cc fluid restriction. R7 was observed on 5-12-09 and 5-13-09 to be in bed with head of the bed elevated. On 5-12-09, R7 stated she was short of breath and concerned of CHF. R7 had on oxygen per nasal canula at 2 liters. R7 was observed to get her lunch tray on 5-12-09 that had a 240 cc glass of red drink and a 240 cc glass of water. R7 was observed to also have a large water pitcher/glass with a lid and straw on her bed side table. On 5-13-09, R7 was observed to have a the large pitcher/glass at her bed side table. At noon meal, R7 received a glass of red drink, a glass of water and a 12 ounce, 360 cc, can of white soda. On 5-14-09 at 11AM, R7's water pitcher was observed to have 300cc's of water with no ice. At 1:22PM, R7 was observed to have her water	F 309		

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F 309	Continued From page 53 pitcher/glass at her over bed table with 900 cc's of ice water. R7 stated the Certified Nurse Aide, CNA had just brought her fresh ice water. E18, CNA, confirmed that she had just filled R7's water pitcher. E18 stated R7 takes fluid well and has no fluid restriction. 2. Record review of R16's May 2009, POS, shows R16 was admitted to the facility on 2-27-09 with a diagnosis, in part, Failure to Thrive, Osteoarthritis and Progressive Polyneuropathy. POS shows an order for an order of 4-6-09 for Vicodin 5/500 1/2 tab every 6 hours and an order for Tylenol 325 mg, 1-2 tablets every 4 hours PRN, as needed, for pain/elevated temp. R16 Minimum Data Set, MDS, of 3-12-09 identifies R16 as having moderate pain daily. R16's COMPREHENSIVE PAIN ASSESSMENT of 3-30-09 identifies R16 scoring a 5 on pain rating scale which is "the worst pain possible". Assessment gives the diagnosis of Peripheral Neuropathy as the cause of pain. R16's Care Plan of 3-13-09 states, "Please monitor me for signs and symptoms of pain during my care and notify my nurse so she can administer pain medication as my physician orders." There is no Care Plan addressing R16's pain other than medication. The facility failed to assess and monitor if R16's Vicodin was controlling her pain. R16 was observed on 5-12-09 at 11:45AM, at noon meal, to be sitting in the Dining Room in a wheel chair waiting for her tray. R16 stated she wanted to go to bed stating she hurt. At, 12:40PM, R16 was still at the Dining Room table complaining of pain and still had not been served her meal. The nurse stated she had just given R16 a Vicodin. At 12:45PM, E1, Administrator, was observed to	F 309		

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F 309	Continued From page 54 take R16 out of the dining room and stated R16 says her back hurts and she doesn't want to eat anything. R16 had still not been served any food or fluids and had been sitting at the table for at least 1 hour per observation. On 5-13-09 at 11:50AM, R16 was observed to be sitting at the Dining Room in a wheel chair waiting for her noon meal. R16 stated she was so sick. Her neck hurts all the time stating it hurt all the way down to her spine. R16 stated she just wanted to go to bed. R16 stated, "Please let me go to bed." R16 was moaning and grimacing and had no food or fluid at the table until 12:30PM. On 5-15-09 at 11AM, R16 was in bed lying down. R16 stated during skin check, that it hurts when she moves and stated she could hardly roll over. On 5-13-09, R16's order for Vicodin was changed to 5/500 twice a day for shoulder pain. 3. Review of the MDS dated 3/24/09 identifies R13 as being an 80 year old female readmitted to the facility on 3/28/08 with diagnoses of Nephritis, Hemiplegia, Allergy and Hypertension among others. The MDS indicates R13 has short/long term memory deficits with moderate cognitive impairment and requires extensive assist of staff for most activities of daily living. The MDS identifies R13 as having moderate pain daily in her back and other areas. The current pressure ulcer sheet identifies R13 as having an "unstageable" pressure ulcer on her right heel. The POS shows R13 receives Hydrocodone-APAP 5-500 tabs 1 tablet every 8 hours (6am, 2pm, 10pm) and has a PRN (as needed) Tylenol 325mg 2 tabs every 4 hours as needed (no indication for use). As of 5/14/09, the care plan in the clinical record did not include a	F 309		

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F 309	Continued From page 55	F 309		

pain management plan with interventions to ensure R13's comfort.

On 5/12/09 at 2:10pm, R13 was in her wheelchair at bedside and complained that her "butt" was "a little sore" as was her right foot/leg which she stated had a "sore on it". E6, CNA transferred R13 to bed and R13 again complained of pain in the right ischial area.

On 5/13/09 at 1:26pm, R13 was transferred to bed complaining that her heel "still hurts." Z1, wound care specialist stated she would try Lidocaine on R13's pressure ulcer prior to doing the treatment due to R13's complaints of pain to see if that helped. No effort was made to see if R13 had any medication available to give prior to the dressing change was done. Z1 applied Lidocaine to the area. R13 did not complain of pain during the cleansing. Following R13's treatment, Z1 wrote new orders for the Lidocaine to be used 15-30 minutes before each treatment.

Review of the MAR shows no Tylenol use by R13 for the month of May. In addition, there is no indication the facility has assessed R13's pain since 9/26/09 as the nurses notes show no entry regarding R13's complaints of leg pain or pain with the treatment or the current effectiveness of the routine Hydrocodone. The PAIN ASSESSMENT dated 9/26/09, which was prior to her developing the pressure ulcer, indicates R13 had no pain at the time and there in no further evidence that any further pain assessments were done.

On 5/15/09 at 10:20am, R13 again complained about lower right leg pain as she rubbed her right leg just below the knee. There in no indication, even though R13 takes routine Hydrocodone, that the nurses assessed R13's for complaints of pain when administering the routine Hydrocodone. The nurses notes reviewed on

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F 309	Continued From page 56 5/15/09 show no entries following Z1's visit and new orders for the lidocaine that would suggest R13's pain was assessed along with the efficacy of the Hydrocodone. On 5/15/09, the care plan coordinator provided a new careplan that included a pain management program. It was dated 12/24/08. The care plan coordinator stated she just needed to pull the plan off the computer as she had done the assessments previously. The facility failed to adequately assess, monitor and treat R13's complaints of pain. 4. Review of the ADMISSION SHEET identifies R14 as being a 58 year old female admitted to the faciltiy on 5/7/09 with diagnoses of Multiple Aneuryms and left craniotomy among others. The physician's order sheet indicates R14 is NPO (nothing by mouth) and has a gastrostomy tube feeding with Nutrin c Fiber ordered to run at 80cc per hour per pump in addition to a 150cc free water flush every 6 hours. The interim care plan dated 5/7/09 identifies R14 as being at risk for falls and wounds but failed to identify what wounds she has. The interim care plan also identifies R14 at risk for dehydration with the goal reading "adequate hydration will be maintained x 21 days.". Intervention indicates staff are to "encourage fluid intake at meals and between", "If refuses fluids offer substitute", "monitor for casues of decreased intake, swalloiwng problem confusion, decreased thirst, etc and address accordingly" and monitor for signs/symptoms of dehydration. There is nothing regarding her NPO status and/or her tube feeding. The interim care plan also identifies R14 to be at risk for pressure ulcers with interventions stating staff are to encourage food/fluid intake and assist as needed, reposition every two hours	F 309		

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F 309	Continued From page 57 and as needed and toilet every two hours, providing pericare after each incontinent episode along with completing skin assessments. R14 is unable to eat/drink or use the toilet. The faciltiy failed to adequately develop an interim care plan to provide for R14's needs. 5. Review of the MDS dated3/10/09 identifies R1 as being a 79 year old female readmitted to the facilty on 8/12/08 with diagnoses of Decubitus Ulcer of lower back, heel and calf, Contractures, Parkinson's Disease, Arthropathy, and Cerebral Vascular Accident among others. The MDS indicates R1 has short/long term memory deficits with severe cognitive impairment and totally dependent on staff for all activities of daily living. According to the clinical record, R1 receives Hospice services. The MDS identifies R1's pain as moderate pain daily. The POS indicates R1 has an order for Morphine Sulphate (Roxanol) 20mg/ml, take 0.5ml every 4 hours as needed. The clinical record contains a care plan from Hospice and one from the facility. There is no evidence that services are coordinated between the Hospice and the facility. The Hospice care plan identifies Pain as evidenced by grimacing, stating painful, the goal is to have pain managed and kept comfortable. The interventions include hospice to assess pain every visit, identifiy pain verses physical pain verses emotional/spiritual suffering, instruct on medication side effects to monitor, and instruct on pain program. The facility care plan reflects no pain management program referred to by the Hospice service. A COMPREHENSIVE PAIN ASSESSMENT dated 3/31/09 indicates R1 has overall pain with date of onset listed as 3/31/09. On 5/13/09 at 9:50am, Z1, wound care specialist, stated they were going to change R1's	F 309		

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F 309	Continued From page 58 dressing to her coccyx pressure ulcer and the ulcer to her outer right leg. Z1 stated she wanted to wait an hour for pain control as R1 had just been given medication and had stated she "hurt all over." At 10:35am, Z1 again was in R1's room and stated "I've never seen her like this." deciding to wait since R1 appeared to be resting comfortably at the time. At 1:07pm, Z1 and E7, treatment nurse came in to do R1's dressing change and R1 appeared comfortable thoughout the treatment. Review of the MAR shows R1's last dose of Roxanol was given on 5/10/09. There is no evidence the facility is routinely assessing R1's pain and or the effectiveness of the pain medication. As of 5/19/09, there is no initial's on 5/13/09 for the Roxanol given that day on recommendation of the wound nurse. A telephone order dated 5/13/09 indicates the PRN (as needed) Roxanol order was discontinued and a new order for Roxanol 10mg given every 4 hours routinely was given. An order is also present for Roxanol 5-20 mg 15 minutes prior to wound care. The nurses notes fail to reflect this information at all so there is no indication as to whether Hospice played a role in this medication change or not. None of this information is reflected on the pain assessment either nor is there any evidence the facility assessed R1's pain prior to the medication change. In addition, there is no evidence the facility has assessed R1's pain control since the medication change. Review of the MAR shows the facility failed to provide the PRN Roxanol prior to getting the routine pain medication ordered. The Hospice note dated 5/8/09 has no intensity of pain identified, indicates the interventions are efffective and states "grimacing" as a nonverbal sign of pain. It states there has	F 309		

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F 309	Continued From page 59 been no PRN doses of Roxanol given in the prior 24 hours. The next note for Hospice is dated 5/14/09 and has no intensity identified. Under Nonverbal signs of pain "none" is written. Pain is identified as an "ongoing problem" and has "Roxanol now scheduled." The assessment identifies the interventions as being "effective." Review of the Hospice Contract indicates under COORDINATION OF SERVICES that Hospice "shall supervise, control, coordinate and evaluate the provision of all services by the facility with at least the same stringency as it supervises, controls, coordinates and evluates the provision of its own services. The Hospice Interdisciplinary Team and Attending Physician shall be responsible for developing, reviewing, revising and evaluating each Plan of Care and assuring continuity beetween all involved agencies and disciplines." The facility failed to coordinate R1's pain management services for R1. 6. R10 is 86 years old with partial diagnoses (from May 2009 Physician's Order Sheet) of: Right Hand Fractures, Congestive Heart Failure, Diabetes Mellitus Type II; Multiple Contusions, Hypertension; Osteoporosis; Obesity, Deep Vein Thrombosis. During initial tour on 5/12/09, R10 was observed seated in her wheelchair, with dark purple bruising noted around both eyes, cheeks, and neck. R10 was identified by facility staff as a resident receiving hospice services. There was no hospice information kept in R10's active chart. Facility staff stated all hospice notes were kept in a separate binder at the nurses station. R10's hospice notes documented she was placed onto hospice services on 3/12/09 with a diagnosis "Debility unspecified." The hospice	F 309		

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F 309	Continued From page 60 care plan dated 3/12/09 addressed problems of: 1. Edema, and 2. Fatigue and Weakness. R23's Physician's Order Sheet documented frequent medication additions and changes: 3/16/09 - Hydrocodone/APAP (Vicodin) 5/500, 1 tablet four times daily. 4/7/09 - D/C (discontinue) Xanax, give Ativan 0.5 mg.(milligrams) twice daily. 4/9/09 - D/C scheduled Vicodin, give Tylenol 1000 mg twice daily. 4/10/09 - Ativan 0.5 mg every 8 hours. Hold if sedated. Ativan 0.5 mg every 4 hours PRN (as needed). 4/30/09 - D/C Ativan, give Xanax 0.5 mg. every 8 hours. Give Xanax 0.5 mg. every 4 hours PRN. 5/1/09 - D/C Xanax - give Haldol 2.5 mg. three times daily and every 4 hours PRN. Hold if sedated. 5/7/09 - Start Xanax 0.5 mg every 8 hours, 0.5 mg. every 4 hours PRN. Taper Haldol to twice daily x 2 days, then evaluate if hallucinations stop. 5/11/09 - D/C Haldol. There was no coordination of services between the nursing facility and hospice. The hospice care plan was not present or integrated into R10's care plan on the active chart. Z3's hospice progress notes were reviewed. Hospice Notes dated 4/28/09 documented under Breath Sounds, R10 had "Rales - Right base, posterior." Z3 described R10 as "anxious, c/o nervousness." Z3 reported edema in bilateral lower legs, 3+ and 4+. Z3 notes a primary diagnosis of CHF. There is no documentation of pulse oximeter readings to rule out hypoxia as the cause of nervousness and agitation. Hospice notes dated 4/30/09 documented rales, right upper and lower posterior lobes. The oxygen saturation was noted at 97% on room air. R10 is noted with "Dyspnea with moderate exertion". R10 is noted to have 3+ and 4+ edema, bilateral lower legs with a note "unable to palpate pedal pulses r/t edema". There are no	F 309		

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F 309	Continued From page 61 new orders to address the edema or absent pedal pulse r/t edema. Hospice notes dated 5/4/09 document R10's fall. She is described on the nurse visit note as "drowsy". Edema 4+ is documented on bilateral lower extremities. There is no documentation of pulse oxygen saturation levels. On 5/6/09, Hospice notes documented rales, dyspnea with moderate exertion. Wounds to R10's face are described as "Excessive bruising et (and) swelling. Right laceration, sutured. Left scabbed." R10 is described as "lethargic". Bilateral edema 3+ and 4+ documented. Pulse oxygen saturation levels are not documented. On 5/20/09, Hospice Care Plan for R10 was presented by the facility. E1, Administrator, verified that the care plans were not together and not integrated with the facility's care plan. 7. R22 was admitted to the facility on 3/27/09. R22's Physician's Order Sheet dated 3/29/09 documented, "Clarification ...Wound Vac to left lower leg wound. Change dressing Q (every) 3 days or PRN.....". R22's Admission Nursing Assessment is dated 3/27/09. The assessment for Skin Condition is not completed. There is no notation in the nursing notes or assessment regarding R22's wound vac, appearance of leg wounds, drainage. There is no weight on the initial nursing assessment. There is a blank Interim Care Plan on the chart with no dates, no name, no problems identified on admission. The Care Plan is a generalized plan placed on all new admissions charts. This generalized interim care plan had not been completed or individualized to address R22's problem with wounds to lower leg, wound vac, dressing changes. R22's Medication Administration Review	F 309		

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F 309	Continued From page 62 (MAR) is incomplete. There is no documentation that medications prescribed were given during the day shift on 3/29/09. 8. R23's chart was reviewed as a closed record. R23's most recent admission to the facility was on 4/8/09. R23's closed record did not contain an Interim or Initial Care Plan that identified his specific nursing care needs. R23's initial Nursing Assessment is incomplete. There is no weight or skin condition documented. There is no diet ordered on the initial physician's order sheet. There is no documentation the physician was called to obtain a diet order for R23. The facility's policy and procedure for admission nursing assessments was reviewed. The policy stated (in part) that admission nursing assessments should include, at a minimum, nursing needs and self-care limitations to determine assistance needed in performing activities of daily living. The standard per policy stated, "Admission Nursing Assessment should be initiated immediately upon admission of a resident.....and completed 24 hours of the admission." 9. R21's POS dated 5/1/09 indicates R21 was admitted on 4/24/09. R21 has a diagnoses in part of; Anemia, Renal Failure, and Diabetes Mellitus II. The interim care plan dated 4/24/09 indicated R21 is at risk for pain and falls, however it fails to identify why R21 is at risk for either of these problems. On 5/12/09, at 10:25 AM, R21 was sitting on his bedside. R21 stated that he was waiting to go to dialysis. R21, showed his right arm where the shunt and access catheter were visible.	F 309		

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F 309	Continued From page 63 On 5/19/09 a review of R21's initial Admission Nursing Assessment failed to show that R21 was a dialysis patient. A review of R21's admission physician's orders dated 4/24/09, failed to indicated that R21 was to go to dialysis, failed to direct staff on the days and place of dialysis, and failed to direct care of R21's shunt or care of the shunt in an emergency. On 5/19/09 a chart review no information from the dialysis center was available. On 5/12/09, at 10:00AM, E30, Care Plan Coordinator, stated the 14 day assessment, raps, and care plan were not completed, and were not available. E30 stated she had just gotten information from the dialysis center, but had not gotten all of the assessments from the other facility departments. E30 was not aware that R21 did not have MD orders to go to dialysis. On 5/21/09, E30 did give a dialysis only careplan to the surveyor that was dated 4/24/09. E30, stated she was aware the careplan was backdated and she would make sure the final copies had the corrected dates. In an interview with E26, Social Service Director on 5/20/09 at 11:10 AM, stated that R21 was going home to his family after completing his physical therapy and would talk with him about discharge planning at that time. When told of R21's concerns, E26 stated that R21 didn't have a phone in his room, and that he had never told her about a trailer. Later that same day E26 stated that she did verify R21's plans to go to a trailer after discharge, not to his wife as they were divorced. E26 stated she had not written / completed a careplan for R21 since his admission. 10. R18's POS, dated May 2009, indicated she had diagnoses of Fractured Right Hip,	F 309		

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F 309	Continued From page 64 Hypertension, Peptic Ulcer , COPD and Congestive Heart Failure. R18's physician's ordered the following pain medications: Tylenol 325 milligrams (mg), take 2 tablets by mouth every four hours as needed; Darvocet-N 100 tablet, take one tablet every four to six hours as needed; and Hydrocodone 5/ 325, one to two tablets, every four to six hours as needed. R18's Pain Assessment, dated 4/8/09, indicated she was having pain in her right hip at a level of 8 (0 being the least amount of pain and 10 being the most excruciating pain). On 5/14/09, at 4:25 PM, R18 was lying in her bed on her back. R18 said "I'm in pain. You know I broke my hip?" R18 indicated she did receive pain medication although she could not recall when she received her last dose. On 5/19/09, at 9:40 AM, during the treatment of her pressure ulcer, R18 indicated to Z1, Consultant Wound Nurse, she has pain in the pressure ulcer when she moves. R18 rated the level of pain at a 5 (0 being the least amount of pain and 10 being the most excruciating). E7, Treatment Nurse, indicated R18 was on a pain medication but she did not recall if it was a routine medication. Z1 noted R18 should receive her pain medication prior to her pressure ulcer treatment. On 5/19/09, R18's Medication Administration Record was reviewed. Each time R18 received her PRN (as needed) pain medication, the staff did not indicate or document the level of pain she was experiencing. Furthermore, the staff documented the following words "helpful", "resting", "asleep", and "relief" when evaluating the result of the medication. There is no further documentation or assessment to indicate what level of relief was obtained by the medication. Furthermore, the facility did not assess and	F 309		

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F 309	Continued From page 65 evaluate if a routine medication would be beneficial. 11. R9's physician's order sheet, dated May 2009, indicated he had diagnoses of Hypertension, Alzheimer's Disease and Anxiety. R9 is currently on Hospice due to Failure to Thrive. R9's physician's order, dated 4/17/09, noted he should receive Roxanol, 10 milligrams, every two hours as needed for pain. R9's Minimum Data Set, dated 3/20/09, documented he had no pain. His care plan, updated on 4/17/09, noted "Has signs of generalized pain at times but is unable to tell staff of location related to decreased cognition". The approaches for this problem noted "Assess effectiveness of pain medication. Assess pain characteristics: duration, location, quality". R9's Medication Administration Record (MAR), dated May 2009, noted he received one dose of Roxanol on 5/5, 5/6, 5/7, 5/9, 5/11 and 5/13/09. There is no documentation in R9's medical record indicating how staff are assessing R9's level of pain. The MAR does not indicate the reason the Roxanol was given or R9's response/efficacy of the medication. R9's Control Substance Sign Out Log noted he received four doses of Roxanol on 5/6/09. This log documents he received three doses of Roxanol on 5/8 and two doses of Roxanol on 5/9/09. These doses are not documented on the MAR. On 5/14/09, at 9:13 AM, E22, Certified Nurse's Aide, CNA, noted "He didn't use to be in pain. Now when you move him, he says 'Ow' all the time. When he starts doing that, I tell the nurse".	F 309		
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of	F 312		

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F 312	Continued From page 66 daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to provide adequate oral care for one (R1) of 21 sampled residents; failed to provide adequate grooming of nails and facial hair for three (R1,R6 and R9) of 21 sampled residents and one (R43) expanded sampled resident; failed to provide complete incontinent care for one (R3) of seven sampled residents who were incontinent of urine. Findings include: 1. On 5/12/09, at 10:28 AM, R9 was in the therapy room. R9 had several days growth of facial hair and brown debris under his fingernails. His facial hair and nails remained in this condition throughout the day. R9's Minimum Data Set, dated 3/20/09, noted he required extensive assistance of two staff persons with grooming. His care plan, dated 3/21/09, noted "assist with shaving as requested and indicated". 2. On 5/12/09, at 11:30 AM, R6 was lying in his bed. R6's fingernails were long with brown debris under them. His fingernails remained in this condition throughout the day. R6's Minimum Data Set, dated 2/3/09, noted he required extensive assistance with grooming.	F 312		

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3. Review of the MDS dated3/10/09 identifies R1 as being a 79 year old female readmitted to the facilty on 8/12/08 with diagnoses of Decubitus Ulcer of lower back among others. The MDS indicates R1 has short/long term memory deficits with severe cognitive impairment and is dependent on staff for all activities of daily living including hygiene. R1 had severe contractures of both hands.

On 5/12/09 at 2:30pm, R1 had long fingernails that had brown substance under the nails. On 5/13/09 at 1:10pm, R1's teeth were observed to be heavily coated with white substance and in need of oral care including brushing her teeth.

4. R3 is 79 years old with diagnoses (from May 2009 Physician's Order Sheet) of: Alzheimer's, Increased Confusion, Hypertension, Debility unspecified. R3's Physician's Order Sheet contained a current order for the anti-psychotic medication Risperdal 0.5 mg. daily.

R3's current MDS is dated 3/20/09. He is assessed as totally dependent on staff for bed mobility, transfer, dressing, eating, hygiene, bathing, toilet use. R3's current care plan updated on 3/19/09 stated that R3 is "unable to assist staff.....minimal to extensive assist...Unable to make needs known r/t dementia..."

On 5/13/09, at 2:40 PM, E44, Certified Nursing Assistant (CNA), entered R3's room to provide incontinent/perineal care for R3. R3's adult diaper was removed. The diaper was saturated with urine, urine was noted on R3's buttocks, posterior thighs, hips. E44 cleaned R3's perineal area, penis and scrotum, turned him onto his left side to clean right hip and buttocks. E44 did not clean his left hip or

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F 312	Continued From page 68 buttocks. 5. Intermittent observations done on 5/12/09 and 5/13/09, during the noon meal, indicated R43 to be sitting in a wheel chair with spastic movements, unable to speak coherently, and at times holding out her hands towards staff and visitors that passed by her. R43 was noted to have brown debris under her nails, and long facial hairs around her mouth and chin. In an interview with E1 and E2 on 5/13/09 at 4:00 PM, no further information was given as to why R43 had not received assistance with grooming in these areas.	F 312		
F 314 SS=H	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to have a system in place for pressure sore prevention, identification, assessment, and treatment for11 (R1, R6, R7, R9, R11,R13 ,R14,R15, R17, R18, and R20) of 24 sampled residents. This failure resulted in harm to R17, who developed an avoidable facility acquired Stage 2 pressure ulcer on the coccyx that declined to a Stage 3. In addition, R17 developed an avoidable facility acquired Stage 2	F 314		

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pressure ulcer on the right hip. This failure resulted in harm to R7 who developed four Stage 2 avoidable facility acquired pressure ulcers that the facility failed to identify, assess and treat. This failure resulted in harm to R13, who developed a facility acquired Stage III pressure ulcer on the right heel which declined to an unstageable pressure ulcer. This failure resulted in harm to R1, who developed a Stage III pressure ulcer which increased in size and is currently an unstageable pressure ulcer. This failure resulted in harm to R18, who developed a facility acquired avoidable Stage III pressure ulcer to her buttocks.

Findings include:

1. Record review of R17's May 2009, Physician Order Sheet, POS, show R17 is a 67 year old female admitted to the facility on 2-22-09, with a diagnosis, in part, Cardiovascular Accident, CVA, and Scoliosis. POS shows an order a tube feeding of 86 cc's/hour of Glytrol for 18 hours a day, on at 12:30PM off at 6:30AM and an order for a No Concentrated Sweet diet. POS shows an order for treatment of Santyl to coccyx, cover with dry dressing BID, twice a day.

R17's Minimum Data Set, MDS, of 3-23-09 shows R17 is totally dependent on staff for bed mobility, transfer, dressing, eating, hygiene, bathing and is incontinent of bowel and bladder. R17's BRADEN SCALE--For Predicting Pressure Sore Risk that is undated and unsigned shows R17 scored an 8 which would indicate severe risk for pressure sore development. Observation of R17 during the Survey reflected that the risk assessment was inaccurate. The facility provided a new Braden Scale assessment dated 5-19-09 that shows she scored a 12 which is at

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high risk for development of pressure sores.

R17's Care Plan of 3-8-09 states R17 was admitted to the facility with open areas to coccyx and to mid back and left ankle. Care Plan states she has decreased mobility and cognition and diagnosis of Failure to Thrive, Alzheimers and recent CVA. Care Plan approach includes, in part: Keep heels floated off the mattress as resident will allow; Skin checks weekly; Document size, drainage, odor and appearance of pressure ulcer per facility protocol as indicated; Make sure R17 is turned and repositioned at least every 2 hours or more frequently if needed; Follow all treatment ordered.

Dietitian Note of 3-20-09 shows R17's food intake at meals is "minimal". "Per staff R17 does not eat much - drinks some and may take a bite of sandwith, but that's about it. Recommendation was to change tube feeding to Glytrol 86 cc hour x 18 hours. Weight is 129.8 lbs. Dietitian Note of 4-30-09 shows a weight loss with weight at 125.5 lbs. and stage 2 pressure sore to left and right coccyx. There is no assessment if R17's current tube feeding order meets her nutritional needs to maintain weight or aid in healing pressure sore. There is no assessment as to what food intake is at meals. (R13 was observed at noon meal on 5-12-09 and 5-13-09 and she refused to eat.)

R17 was observed on 5-12-09 during tour of the facility to be up in a geriatric chair with a lap tray in her room at 9:40AM and was still there at end of tour at 10:40AM. R17 was observed to be in the dining room at 11:45AM sitting in her geriatric chair with lap tray. R17 got her tray at 12:59PM. At 1:05PM, R17 was still up in her geriatric chair in the Dining Room. At 2:30PM, R17 was observed to be in bed and tube feeding was not on. There was a full bottle of tube feeding hanging on the tube feeding poll that had

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F 314	Continued From page 71 not yet been spiked or attached to R17's G tube. (Tube feeding order states to start at 12:30PM.) On 5-13-09, R17 was observed in the Dining Room in her Geriatric chair with a lap tray at 11:59AM. At 1:12PM, R17's tube feeding still was not running. E15, Register Nurse, RN, was in R17's room and Surveyor requested to do a skin check. R17 was observed to have a stage 3 pressure sore on her coccyx with no dressing on the pressure sore and none in the bed or around the bed. R1's right hip had a red non blanchable pressure sore the size of a golf ball with no dressing. E15 confirmed the pressure sores and stated he would tell the Treatment Nurse that R17 needs a dressing. At 1:25PM, E15 started R17's tube feeding. At 5:03PM, E23, Licensed Practical Nurse/Treatment Nurse, was asked to do a skin check on R17. R17 had a bandage on the coccyx and there was no treatment to the pressure sore on the right hip. E23 stated that Z1, Wound Consultant Nurse and E7, Treatment Nurse, had just put on the dressing on R17's coccyx. E7 confirmed Z1 had just assessed R17's coccyx and did a treatment within the past hour. E7 confirmed the pressure sore on the coccyx is a stage 3 and stated it measured 2.0 cm x 1.0 cm x 0.3 cm . (Facility WEEKLY PRESSURE LOG of 5-6-09 identified the pressure sore on the coccyx as being a stage 2 measuring 1.0 x .5 x .3 cm). E7 stated that R17 is now on Hospice and they would get an air loss mattress. E7 stated the pressure sore on the coccyx was the only pressure sore. E7 was informed by the Surveyor of the red area on R17's right hip. R17 was observed on 5-14-09 from 9:18AM to 10:40 AM, every 7 to 15 minutes to be up in a geriatric chair with a lap tray in the 400 Hall. At	F 314		

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F 314	Continued From page 72 10:40AM, E2, Director of Nursing, was observed to tell staff that R17 needed to lay down. At 10:50AM, E19, Certified Nurse Aide, CNA, stated she had gotten R17 up that morning at around 8:30AM. The facility WEEKLY PRESSURE LOG for 5-13-09 identifies R17's Pressure Sore on her Coccyx as being acquired in house on 3-11-09 now a stage 3 with the above measurements. The WEEKLY PRESSURE LOG does not identify the pressure sore on R17's right hip. R17's POS shows an order of 5-13-09 to discontinue previous treatment to the coccyx and start new treatment to cleanse and apply Santyl and cover with dry dressing and change twice a day and PRN. (Yet record review of the POS shows the facility had been using Santyl since March when the pressure sore was identified.) The POS show an order of 5-13-09 at 11PM to apply wound gel with dry dressing to R17's right hip daily and PRN. Nurses Note of 5-13-09 at 11PM states noted red area on right hip had small blister on right hip that opened. Turn and Position on right side only for 1 hour at a time. Applied wound gel with dressing. On 5-15-09, E7, provided a written note stating R17 had a stage 1 on her right hip measuring 4.5 cm x 3.2 cm pink and blanchable with a blister measuring 1.0 x 1.0 cm in the center. When questioned, E7 stated she considered the area on R17's hip to be a stage 1 because the blister was not opened. (Facility Policy and Procedure that is undated shows a blister would be staged as a stage 2 pressure sore.) On 5-19-09, Z1, stated R17's pressure sores were avoidable and she had talked to the facility owner of her concerns. Z1 stated she thinks the CNA's are taking off residents pressure sore	F 314		

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F 314	Continued From page 73 dressings during care and then not telling the nurses the resident needs a new dressing. 2. Record review of R7's May 2009, POS, shows R7 is an 80 year old female admitted to the facility on 1-17-06, with a diagnosis, in part, Diabetes Mellitus and Congestive Heart Failure. POS shows an order to apply proshield plus after each incontinent episode and as needed to the Coccyx/Perineum. During tour of the facility on 5-12-09, R7 was identified as being a reliable interview and as being a double amputee. Hospital PATIENT TRANSFER FORM (NURSING ASSESSMENT) dated 4-6-09 states R7 has a stage 2 pressure sore to her Coccyx with order for Sensicare Cream. Record review of R7's Basic Metabolic Panel of 5-7-09 showed labs were within normal limits. Nurses Note of 4-6-09 states R7 was readmitted to the facility and states, "Coccyx area has small opened L (left) buttock side superficial. Orders for topical. Resident refuses to lay side to side - pillow positioned under hip-Also refused to remove brief at HS (bed time)..." There are no further notes of the pressure sore on R7's coccyx in Nurses Notes until 5-14-09 and no further notes of R7 refusing to lay down or reposition. There is nothing on the facility WEEKLY PRESSURE LOG from 4-6-09 through 5-13-09 showing R7 had any pressure sores. On 5-12-09 and 5-13-09, R7 was observed throughout the day to be in bed with her head of bed elevated and laying on her back. R7 had oxygen on per nasal cannula and stated she didn't feel good. R7 stated she has shortness of breath and stated she was concerned of CHF. On 5-14-09 at 10:08AM, E2, Director of Nursing, was observed in R7's room beginning to	F 314		

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F 314	Continued From page 74 do incontinent care. R7 had on a disposable incontinent brief that was saturated with urine. R7 stated she had last been cleaned at around 7AM. Surveyor requested to do a skin check and noted an open pressure sore on R7's coccyx/left buttock area (this did not appear to be new), and three open pressure sores on her right back upper thigh area. R7 had a thin coat of BM smeared on her right upper back thigh. R7 was observed to have formed stool at the rectum. E2 confirmed the smeared feces at the back upper thigh and the formed stool at the rectum, which would reflect R7 had not been cleaned properly the last time she was given incontinent care. Interview with E7 at 10:22AM reflected R7 had no pressure sores. E7 was informed of pressure sores that were from the above observation. On 5-14-09, E7 provided an assessment of R7's pressure sores. The pressure sore on left buttock/coccyx area was assessed as a stage 2 measuring 1.2 x .3 cm. The pressure sores on the right upper back thigh were also identified as Stage 2 pressure sores measuring .5 x .5 cm, .7 x .2 cm and .4 x 2.5 cm. The assessment stated R7 refused care on 5-15-09 and was provided patient teaching with positive effect. Loose stool noted x 1. Implemented treatment to areas. Record review of R7's MDS of 5-10-09 reflected she resists care and requires extensive assistance of 2 for bed mobility and is dependent on staff for transfer. MDS states R7 requires extensive assistance with hygiene and is frequently incontinent of bowel and bladder. MDS shows no pressure sores identified. R7's BRADEN SCALE assessment of 4-6-09 shows a score of 14 which is "moderate risk". R7's Pressure Ulcers Resident Assessment Protocol, RAP, of 5-10-09 states, "R7 has no open or red areas noted at this time she does	F 314		

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F 314	Continued From page 75 turn and reposition herself in bed but needs extensive assist of staff to pull self up in bed and turning all the way over to her side. She does not like to lay on her side and will tell staff she does not want to turn over." The facility provided a Care Plan of 3-12-09 as R7's most current Care Plan on 5-15-09. This Care Plan identifies R7 has the potential for skin breakdown due to assist need with mobility and incont. of bowel and bladder. Care Plan approaches include in part: Assist with repositioning at least every 2 hours and PRN; Keep skin clean and dry; Report any red or open areas; Document size, drainage, odor and appearance of pressure ulcers; Remind R7 of the consequences of refusal to lay down. (There are no other approaches or interventions identified to address R7's refusal to lay down.) The facility provided another Care Plan on 5-19-09 that was dated 5-10-09 that stated R7 "Is at risk for skin breakdown related to bilateral amputee of lower extremities, incontinent of bowel and bladder, requires extensive to total assist with all bed mobility, requires transfer with mechanical sling lift. Refuse to lay down in evening after gotten up in afternoon. Has no open areas noted at this time. Staff does continue to encourage her to turn over onto side but she will often refuse due to watching tv, visiting, or just because she does not like to lay on her side." (This was not on the RAP of 5-10-09.) New Care Plan approaches, include inpart: Do weekly skin checks; Administer medications as ordered; Assist out of bed several times daily; Assist/teach resident to reposition self; Assist resident to reposition self when up in wheel chair at least every 2 hours and prn; Notify nurse, physician and family of any signs or symptoms of skin breakdown; Staff to	F 314		

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encourage her to lay down every 2 hours and prn when up in wheel chair and to turn on side to assist with prevention of skin breakdown. (There are no interventions that staff are to use when R7 remains in bed all day due to shortness of breath or not feeling well. Nurses Note of 4-27-09 states R7 had not been out of bed for 4 days due to not feeling well and shortness of breath. And R7 was observed all day in bed on 5-12-09 and 5-13-09 and stated she was not getting out of bed due to not feeling well and shortness of breath.)

Z1 stated on 5-19-09, that she had not seen R7, but she has told staff that residents should not be wear disposable incontinent brief when in bed as they hold in moisture and increase the risk of developing a pressure sore.

3. Record review of R11's May 2009 POS, shows R11 is an 85 year old female who was admitted to the facility on 2-27-09 with a diagnosis, in part, Anemia, Dehydration and Feeding Disorder. POS shows an order for 39 cc's of Nutren 2.0 via G tube for 20 hours a day. Tube feeding is to be on at 10AM and off at 6AM. R11 also has an order for a Pureed Diet. POS shows an order for a urinary catheter.

Record review of R11's MDS of 3-29-09 shows R11 is totally dependent on staff for transfer, eating, hygiene and requires extensive assistance with bed mobility. MDS show a urinary catheter and that R11 is incontinent of bowel.

R11's Care Plan of 3-5-09 states R11 was admitted to the facility with open areas to coccyx and left ankle. Care Plan approaches include, in part, to encourage R11 to reposition self when up in geriatric chair at least every 2 hours and prn; keep skin clean and dry.

R11 was observed on 5-12-09 to be up in her

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F 314	Continued From page 77 geriatric chair at 12:10PM in the Dining Room and remained in the chair until 2:17PM when she was transferred to bed. Interview with E12, CNA reflected that the night shift gets R11 up in the morning and she was already up when E12 came to work. E12 confirmed R11 had not been out of her chair since then. E13, Physical Therapist, and E14, Physical Therapist Aide, stated on 5-12-09 at 3:02PM, that R11 had been in therapy for short wave diathermy for a pressure sore on her ankle, that morning, and had not been out of her geriatric chair during the process. E14 stated at 11:53AM, R11 was taken from therapy to the Dining Room. (During the time of observation from 12:10PM to 2:17PM, R11's tube feeding was not connected and running as ordered.) At 2:17PM, R11 was observed to be transferred to bed. R11 had a urinary catheter and was wearing a disposable incontinent brief that had a wet area 12 inches in diameter of tea colored urine. E12 failed to wash R11's buttocks that had been soiled with urine. 4. Review of the MDS (Minimum Data Set) dated 3/24/09 identifies R13 as being an 80 year old female readmitted to the facility on 3/28/08 with diagnoses of Nephritis, Hemiplegia, Allergy and Hypertension among others. The MDS indicates R13 has short/long term memory deficits with moderate cognitive impairment and requires extensive assist of staff for bed mobility and transfers. The MDS indicate R13 is on a schedule toilet plan due to incontinence and has pressure ulcers (stage III). According to the Braden scale dated 9/26/08, R13 is at low risk for pressure ulcers. The care plan identifies R13's pressure ulcer as being on the right heel and a stage III. Interventions include staff documenting size, drainage, odor and appearance of pressure	F 314		

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F 314	Continued From page 78 ulcer per protocol, encouraging fluid intake on all shifts, turn/reposition at least every two hours or more frequently if needed, report any red areas, and do weekly/prn (as needed) skin checks among others. Weekly documentation indicates R13's pressure ulcer was identified as in-house acquired on 10/25/08 with no justification/cause as to why she developed it. Laboratory results do identify R13 as having a low total protein (5.3) and Albumin (2.9). R13 currently has orders for her heel pressure ulcer to be cleansed then apply santyl/Bactroban ointment with an alginate dry dressing daily. On 5/12/09 at 11:33am, R13 was in her wheelchair in the beauty shop. R13 had a multipodus boot on her right foot. At 12:10pm, R13 was taken directly to the dining room from the beauty shop without toileting and/or repositioning. R13 was noted to eat independently and at 1:12pm, was back in her room at bedside. R13 was observed at 1:25pm, 1:30pm, 1:35pm and 1:40pm to remain at bedside in her wheelchair. At 2:10pm, R13 was still at bedside and complained that her "butt" was "a little sore" as was her right foot/leg. E6, CNA (certified nurses aide) transferred R13 to bed without first toileting her. R13's right foot was wrapped in gauze and had drainage obvious throughout the outside circumference of the heel. R13's feet were noted to hang over the end of the bed. R13's paper incontinent brief was wet with urine and R13 complained of pain in the right ischial area as E6 removed the brief. R13's upper thighs and buttock area was deep creased and red. R13 complained of pain when E6 cleansed the ischial area stating "that's the sore spot." No fluids were offered. R13's feet remained hanging over the end of the bed as they were lifted on a pillow.	F 314		

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F 314	Continued From page 79 Review of R13's POS (Physician's Order Sheet) shows an order for Proshield to be topically applied after each incontinent care. No ointment was applied following the incontinent care observed on 5/12/09. In addition, the POS also states R13 should have two boots on which she did not. Review of the weekly pressure ulcer documentation dated 5/6/09 failed to reflect the drainage observed on R13's dressing. The pressure sore was also noted to have declined going from a stage III to "unstageable" measuring 3.0cm x 3.0cm from 3.0cm x 2.0cm the week before (4/29/09). R13 is being seen by a wound specialist (Z1). On 5/13/09 at 9:38am, R13 was up in her wheelchair at bedside. Interview with Z1, Wound Specialist, indicated R13 doesn't lay down until after lunch so her treatment won't be done until then. R13 was again observed to remain in her wheelchair throughout the morning at at 11:22am was observed in the activity room dosing in her chair. At 1:26pm, R13 was transferred to bed complaining that her heel "still hurts." Again, R13's bed appeared too short with her feet extending over the foot of the bed lifted on pillows. Z1 stated she would try Lidocaine prior to doing the treatment due to R13's complaints of pain. R13's heel dressing had obvious drainage through the dressing. Z1 stated she had not noted that before but stated the drainage had no odor. R13's right heel wound bed was on the bottom of the heel and had some slough/dark areas noted along with red beefy areas. The wound bed was cratered in the center and the edges were white. Z1 and E7, treatment nurses were observed to change the dressing with Z1 removing and cleansing the wound, E7 applying santyl/Bactroban ointment and a dry dressing.	F 314		

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No handwashing was done by either nurse during the course of the dressing change although they were noted to change gloves and apply alcohol gel in between tasks. Z1 stated the wound bed appeared a lot cleaner and a "little smaller." Z1 was asked about the origin of the heel ulcer and stated she was unaware. Z1 was asked if it was a possibility that R13's feet rested on the foot board of the bed since the bed was too short and stated she was unsure. Following the treatment on 5/13/09, Z1 wrote new orders for Lidocaine to be administered prior to the dressing change and increased the treatment to twice daily rather than once daily. This is the first change in treatments in the past 6 weeks even though a wound bed decline was noted on 4/29/09. There is no new orders or documentation on R13's ischial area as of 5/15/09.

Documentation of the original wound site noted 10/25/08 was requested on 5/13/09 and as of 5/15/09, none had been provided. The facility has failed to provide any evidence that R13's pressure ulcer development was investigated in an attempt to determine what the cause was. On 5/19/09, nurses notes dated 10/25/09 show a new order received for right heel but fails to indicate why the order was received. On 5/19/09, a wound report dated 11/21/08 was provided that identified R13's heel pressure ulcer identified on 10/25/08 was necrotic and measured 7.4cm x 8.2 cm with drainage. There is no indication as to why the facility did not identify this pressure ulcer before it was necrotic and this large. The facility has been unable to provide any additional information.

The facility failed to adequately assess R13's risk for pressure ulcer development and failed to assess her risk quarterly since she is currently

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F 314	Continued From page 81 assessed at a low risk and has pressure ulcers. The facility failed to implement the pressure ulcer prevention plan for R13 in that they failed to reposition/toilet R13 timely, failed to provide barrier cream as ordered by the physician and failed to adequately identify change in R13's pressure ulcer when it started to show drainage. 5. Review of the ADMISSION SHEET identifies R14 as being a 58 year old female admitted to the faciltiy 5/7/09 with diagnoses of Multiple Aneuryms and left craniotomy among others. The interim care plan identifies R14 to be at risk for pressure ulcers with interventions stating staff are to encourage food/fluid intake and assist as needed, reposition every two hours and as needed and toilet every two hours, providing pericare after each incontinent episode along with completing skin assessments. On 5/12/09 at 10am during the initial tour of the building, R14 was observed to be laying flat in bed. R14 had no preventative measures such as heelbos on her feet which were laying flat on the mattress. At 11:35am, R14 was observed to be in bed with the head of the bed elevated. R14 remained in this position until 1:46pm when the observation stopped. The facilty failed to ensure that her interim care plan was followed for turning and repositioning every two hours. 6. Review of the MDS dated3/10/09 identifies R1 as being a 79 year old female readmitted to the facilty on 8/12/08 with diagnoses of Decubitus Ulcer of lower back, heel and calf, Contractures, Parkinson's Disease, Arthropathy, and Cerebral Vascular Accident among others. The MDS indicates R1 has short/long term memory deficits with severe cognitive impairment and totally dependent on staff for all activities of daily living.	F 314		

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F 314	Continued From page 82 The MDS indicates R1 is incontinent of bowel and bladder and has moderate pain daily. The Braden Scale last done on 9/2/08 indicates R1 is at moderate risk for pressure ulcer development even though she was admitted with pressure ulcers. According to the care plan dated 3/10/09, R1 has 2 opne areas, one to her coccyx and one to her right lateral knee. The goal is to be free of infection with current treatment and continue healing as evidenced by decrease in size. The interventions include floating heels, adequate fluid/food intake, document size, drainage, odor and appearance of open areas per facility protocol, "make sure res (resident) is turned and repositioned at least every 2 hours or more frequently if needed, and treatments as ordered among others. The physician's order sheets (POS) indicate R1 is to have a dressing with Silver Alginate changed three times daily and as needed to coccyx wound which is identified as a stage III on the weekly skin report. On 5/12/09 at 11:33am, R1 was turned to her right side with the head of bed slightly elevated. R1 remained in this position through lunch. At 2:30pm, R1's skin was checked and she was turned at that time. The facility failed to reposition her at least every two hours as indicated in her care plan. On 5/13/09 at 9:28am, E6, CNA, turned R1 over and R1 was noted to have no dressing on her coccyx pressure ulcer and there was no dressing in the bed with her. At 9:50am, Z1, wound care specialist, stated they were going to change R1's dressing and wanted to wait an hour for pain control. Z1 stated as dry dressing had been applied to her coccyx in the interim. At 1:07pm, Z1 and E7, treatment nurse came in to do R1's dressing change. Z1 and E6, alternated cleansing the wound and dressing it, neither	F 314		

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F 314	Continued From page 83 washing their hands inbetween but using alcohol instead of soap and water. R1's coccyx wound treatment was done the same way. On 5/14/09 at 11:20am, E9 and E10, Restorative Aides entered R1's room to weigh her using the mechanical lift. R1 was rolled to her side to remove the lift pad and R1 was observed to have no dressing on her coccyx wound. The incontinent pad under her had a softball size area of drainage noted on it which had a ring of dried drainage on the circumference. There was no dressing in the pad at the time. Review of the Wound Specialist skin report dated 4/28/09 identifies the chief complaint being "deterioration" of the leg wound and followup to the coccyx wound. Measurements done at that time indicate the leg wound measured 1.5cm x 1.5cm x 0.3cm depend dar in center with scant ser/sanguneous drainage. The coccyx measured 4.3cm x 1.7cm x 1.5cm with undermining at 12:00 - 3.7cm, 6:00 - 1.3cm, 3:00 - 1.4cm and 9:00 - 3.0cm. The report identifies the wound edges as "rolled" and the wound having moderate amount of sero/sang drainage. Measurements according to the WEEKLY PRESSURE LOG show a decline identified on 5/6/09 as the 4.5cm x 2.5cm x 1.8cm , unstageable, with tunnelling showing slight improvement although the overall measurements show increase in size. Measurements taken on 5/13/09 show a slight improvement of some measurements while showing a slight decline in others. Both areas have rolled edges. The facility failed to ensure that R1 was turned and repositioned timely, failed to ensure that treatments were in place and timely according to the physician's orderstreatments and care plan.	F 314		

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F 314	Continued From page 84 7. Review of the MDS dated 2/20/09 identifies R20 as being readmitted on 11/17/08 with diagnosis of Acute Renal Failure, Diabetes Mellitus, Hypertension and Osteoarthritis. The MDS indicates R20 requires extensive assist of one staff for all activities of daily living including mobility and transfers. The MDS indicates R20 is occasionally incontinent of bowel and bladder and has a history of pressure ulcers as recent as April 2009.. On 5/6/09, a new order was written stating "continue Baza x 2 weeks and then dc." The care plan under risk for pressure ulcers indicates staff are to encourage resident to reposition self every two hours when up in chair, keep skin clean and dry, and report any red areas along with toileting before and after meals and as needed. The braden scale dated 3/6/08 identified R20 at a "low" risk. There has been no subsequent assessments. On 5/12/09 at 9:35am, R20 was observed in her wheelchair in the corner of the activity room. At 1:35pm, R20 stated staff was going to change her diaper as she was taken into her room. E6, CNA, removed R20's urine soaked paper incontinent brief and R20 complained that her "bottom" was a little sore and her ischial areas looked red and irritated. E6 gave incomplete incontinent care and then placed a dry brief on her. No ointment was applied and no toileting was offered and/or encouraged per the care plan. R20 was transferred back into her wheelchair where she said she would stay until after supper. On 5/13/09, R20 stated her routine is to have her brief changed after breakfast, lunch and supper. R20 stated she gets up after breakfast and stays in her chair until after lunch when they change her diaper. The facility failed to provide timely repositioning, appropriate incontinent care and barrier ointment as ordered by the physician.	F 314		

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F 314	Continued From page 85 8. R15's Physician's order sheet dated 5/1/09 indicated a diagnoses in part of; Neurogenic Dysphagia, Hemiplegia, Parotis Left Face, Gastrostomy Tube (g-tube) and Catheter. A recent laboratory result dated 5/11/09 indicated R15 had a positive result for C-Difficile (C-Diff) in her stool. The most recent care plan dated 4/20/09 indicated R15 is to have an assist of one staff for all toileting and hygiene activities. The most recent care plan dated 5/13/09 indicated; a new diagnosis of C-Diff, routine skin assessments, good hygiene, universal precautions. The care plan also indicated; reddened area on buttocks, assist to turn, incontinent of stool, use pressure relief mattress. The most recent Braden Assessment done on 4/13/09 indicated R15 scored at level 16, making her a high risk for pressure ulcers. On 5/12/09 at 10:20 AM, was laying on her back in bed with her head elevated at a 30 degree angle. R15 was also observed at 10:40 AM, and 11:25 AM lying on her back in bed with her head elevated. At 11:50 AM, R15 was brought in a wheel chair to the dining room for lunch. After lunch, R15 was returned to her room and sat in her wheel chair until 2:26 PM when put to bed for peri care. At this time it was noted that R15 had been sitting for 2.5 hours with no pressure relief in her wheel chair. At 2:26 PM, E18, Certified Nurses Aide, provided peri care to R15. E18, Certified Nurses Aide (CNA), removed a diaper from R15 and at this time it was noted that R15's peri area and upper inner thighs were bright red. After cleansing the peri area, E18 turned R15 to her left side to complete care. At this time it was noted that R15's buttocks was covered with a foul smelling, sticky brown stool. After removing the	F 314		

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F 314	Continued From page 86 stool, it was noted that both of R15's buttocks were deeply reddened and excoriated in appearance. After completing peri care, E18 turned R15 again onto her back and did not provide a change of position or ask the resident to change hr position, to give relief to R18's excoriated buttocks. On 5/15/09, at 4:00 PM, in an interview with E2, Director of Nurses, no further information was given as to why R15 was not given pressure relief in her wheel chair, or offered/reminded to turn herself to provide pressure relief from her back / buttocks when in bed. On 5/27/09, a review of the facility Wound Prevention Policy and Procedure indicated #1-turn schedule in room, #2-reposition per turn schedule, #3-pressure relief cushion in chair. 9. R18 was admitted on 4/8/09. R18's physician's order sheet, dated May 2009, noted she had diagnoses of Right Hip Fracture, Hypertension, Peptic Ulcer, COPD, Congestive Heart Failure and Constipation. R18 had no pressure ulcers on admission to the facility. R18's nurse's note, dated 4/20/09, noted "Res (daughter) informed her of open areas to buttocks and new tx (treatment)". There was no measurement of these areas in R18's medical record. The facility's treatment record, dated 4/28/09, noted she acquired a Stage III pressure ulcer, on 4/25/09, on her right ischium measuring 3.0 centimeters (cm) by 2.5 cm with 0.3 cm depth with slough. In addition, she acquired a Stage II pressure ulcer, on 4/25/09, on her left ischium measuring 1.5 cm by 1.3 cm with 0.3 cm depth. The physician ordered a treatment of Santyl (a debriding agent) and cover with a dry dressing daily and as needed. Furthermore, staff were to monitor her heels for redness. There was no	F 314		

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F 314	Continued From page 87	F 314		

documentation in R18's medical record indicating these pressure ulcers were unavoidable.

On 5/14/09, at 4:25 PM, R18 was lying on her back in bed. R18 heels were not floating and were lying directly on the mattress. R18 responded "yes" when asked if she had any pressure ulcers on her buttocks.

On 5/19/09, at 10:50 AM, R18 was lying in bed on her back. She indicated her buttocks hurts. She said "When they put stuff on it, it burns." Again, R18's heels were not floated and were lying directly on the mattress.

R18's Braden Scale (for Predicting Pressure Sore Risk), dated 4/8/09, noted she had a score of 16 (total score of 12 or less represents a high risk for skin breakdown).

R18's Minimum Data Set, dated 4/21/09, noted she required extensive assistance with bed mobility, transfers and ambulation. R18's Interim Care Plan, dated 4/8/09, noted she had a surgical wound but did not indicate she had any pressure ulcers. The facility did not provide any care plan to address R18's current pressure ulcers.

10. R9's physician's order sheet, dated May 2009, noted he had partial diagnoses of Alzheimer's Disease, Anxiety, Dementia and Dehydration. R9 was readmitted to the facility on 4/15/09. The Hospital's Nursing Home Discharge record, dated 4/15/09, noted he had a blister to his right heel. His admission nursing note indicated he had no opened areas upon readmission. Upon admission to the facility, R9 was placed on Hospice for Failure to Thrive.

The facility's Weekly Pressure Ulcer Logs for 4/22 and 4/28/09, had no documentation regarding a blister on R9's right foot.

R9's nurse's note, dated 4/29/09 noted "An

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F 314	Continued From page 88 opened area to bottom both R (Right) (and) L (Left) sides are reddened and excoriated noted." There was no measurements or monitoring of these areas in R9's medical record. R9's physician's order, dated 4/29/09, noted he should receive Vitamin C, 500 milligrams (mg), twice daily, a multivitamin daily, wounds should be cleansed daily with normal saline and wound get and cover with a dry dressing daily. The facility's Weekly Pressure Ulcer Log, dated 5/6/09, noted R9 had acquired a Stage III pressure ulcer on his right ischium measuring 1.0 centimeters (cm) by 1.0 cm 0.3 cm depth. He had also acquired Stage III pressure ulcer to his left ischium measuring 0.7 cm by 1.0 cm by 0.3 cm depth. In addition, he had a Stage II pressure ulcer to his right heel measuring 5.0 cm by 4.0 cm fluid filled blister. On 5/7/09, R9's physician ordered to cleanse the right and left buttocks with normal saline, apply Santyl (a debriding agent) and cover with a dry dressing twice daily and as needed. In addition, the physician ordered skin prep to R9's right heel twice daily and staff were to float his heels while in bed. R9's care plan, updated on 4/29/09, noted he had open areas to his left and right buttocks. the care plan did not address the pressure ulcer on his heel. On 5/12/09, at 10:30 AM, R9 was in his geriatric chair with a lap top cushion. At 11:35 AM, R9 was in the main dining room. He remained in the dining room until 1:30 PM. At 1:50 PM, E21, Licensed Practical Nurse (LPN), and E18, Certified Nurse's Aide (CNA), assisted R9 to bed. E21 and E18 removed R9 dry adult diaper. There was no dressing on R9's buttocks. Furthermore, E21 and E18 confirmed R9 had been in his geriatric recliner since at least 10:30	F 314		

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F 314	Continued From page 89 AM without a change in position. E21 and E18 did not float R9's heels after placing him in bed. At 2:15 PM, R9 was lying bed with his heels directly on the mattress. 11. R6's physician's order sheet, dated May 2009, noted he had a partial diagnoses of Bilateral Lower Extremities Cellulites, Dementia and General Weakness. R6's Minimum Data Set, dated 2/3/09, noted he required extensive assistance with bed mobility. His care plan, 5/4/09, noted "I am unable to reposition self while in bed without assistance due to generalized weakness. " R6 was seen in bed on 5/12/09, at 11:30 AM, with his heels lying directly on the mattress. He was lying on his right side and his knees were touching. He had no type of pressure relieving device between his knees. From 2:04 PM until 2:30 PM, he was seen in bed with no type of pressure relieving device between his knees. Furthermore, his heels were lying directly on the mattress.	F 314		
F 315 SS=E	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by:	F 315		

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F 315	Continued From page 90 Based on observation, interview and record review, the facility failed to provide incontinent care in a manner which prevents urinary tract infections for three (R11, R20 and R15) of seven sampled residents requiring incontinent care; the facility failed to encourage and offer toileting per plan of care for two (R13 and R20) of five sampled residents on a toileting program. 1. Record review of R11's MDS of 3-29-09 shows she is incontinent of bowel, has a urinary catheter and is totally dependent on staff for hygiene. R11 was observed on 5-12-09 at 2:17PM to be transferred to bed by E12 and E19, CNA's. R11's cloth bag holding her urinary catheter bag was soiled. R11's catheter bag was observed to be lifted above her bladder and the urine in the tubing backflowed. R11 was wearing a disposable incontinent brief that was wet with tea colored urine approximately 12 inches in diameter. E12 was observed to remove the soiled incontinent brief and wipe feces from the anal area and wipe the catheter tubing, wearing the same gloves. E12 did not wash R11's buttocks that had been soiled with urine. 2. Review of the MDS (Minimum Data Set) dated 3/24/09 identifies R13 as being an 80 year old female readmitted to the facility on 3/28/08 with diagnoses of Nephritis, Hemiplegia, Hematuria and Hypertension among others. The MDS indicates R13 has short/long term memory deficits with moderate cognitive impairment and requires extensive assist of staff for bed mobility and transfers. The MDS indicates R13 is on a scheduled toilet plan due to incontinence. The Physician's Order Sheet (POS) shows R13 receives Lasix 20mg daily. The care plan identifies R13's incontinence and shows a goal to	F 315		

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F 315	Continued From page 91 have no breakdown as a result of incontinence. Interventions indicate staff are to assist resident to and from the bathroom and encourage her to tell staff of toileting needs early so that have time to get her to the bathroom in time and "encourage resident to go to the bathroom before and after meals and assist as indicated, and keep call light within reach at all times among others. The laboratory section indicates R13 has a history of UTI's (urinary tract infection) on 1/21/09, 9/2/08, 7/22/08 and 7/8/08 all culturing E. Coli >100,000 col. The nurses notes dated 4/16/09 indicate R13 had a urinary catheter discontinued due to blood in her urine. On 5/12/09 at 11:33am, R13 was in her wheelchair in the beauty shop. At 12:10pm, R13 was taken directly to the dining room from the beauty shop without toileting. At 1:12pm, R13 was back in her room at bedside. Her call light was not within reach nor was her fluids and she was not toileted when returned from the dining room as indicated in her care plan. R13 was observed at 1:25pm, 1:30pm, 1:35pm and 1:40pm to remain at bedside in her wheelchair. At 2:10pm, R13 was still at bedside and E6, CNA transferred R13 to bed without first toileting her. R13 had a paper incontinent brief on which was soaked with urine. Following incontinent care, no fluids were offered as indicated in her care plan. Review of R13's EVALUATION OF BOWEL AND BLADDER TRAINING dated 6/26/08, R13 does not tell staff of toileting needs and are to continue scheduled toileting upon getting up in morning, before meals, before bedtime and during 2 am rounds. The facility has failed to follow both R13's care plan and their evaluation suggestions in an effort to maintain R13's continency.	F 315		

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F 315	Continued From page 92 3. Review of the MDS dated 2/20/09 identifies R20 as being readmitted on 11/17/08 with diagnosis of Acute Renal Failure, Diabetes Mellitus, Hypertension and Osteoarthritis. The MDS indicates R20 requires extensive assist of one staff for all activities of daily living. The MDS indicates R20 is occasionally incontinent of bowel and bladder. The care plan under risk for falls indicates staff are to toilet R20 before and after meals and as needed. On 5/12/09 at 1:35pm, R20 stated staff was going to change her diaper. E6, CNA, pushed R20's wheelchair toward the sink and locked the wheels. R20 then stood up against the counter top as E6 pulled her pants down and removed her urine soaked paper incontinent brief. E6 wiped R20's rectal areas with three rags, dried the area and placed a clean dry brief on her. No cleansing was done to the front or periarea. No toileting was offered and/or encouraged. On 5/13/09, R20 stated her routine is to have her brief changed after breakfast, lunch and supper. The facility failed to provide timely incontinent care to R20 and failed to toilet her according to the care plan and her identified needs. 4. R15's Physician's order sheet dated 5/1/09 indicated a diagnoses in part of; Neurogenic Dysphagia, Hemiplegia, and Catheter. A recent laboratory result dated 5/11/09 indicated R15 had a positive result for C-Difficile (C-Diff) in her stool. The most recent care plan dated 4/20/09 indicated R15 is to have an assist of one staff for all toileting and hygiene activities. The most recent care plan dated 5/13/09 indicated; a new	F 315		

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F 315	Continued From page 93 diagnosis of C-Diff, routine skin assessments, good hygiene, universal precautions. On 5/12/09, at 2:26 PM, E18, Certified Nurses Aide, provided peri care to R15. E18 loosened the diaper from R15 and rolled the front flap down toward R15's peri-anal area. A smell of feces was noted and R15's peri area and upper inner thighs appeared bright red. E18 began by washing R15's peri area, taking a soapy cloth E18 wiped downward into R15's groin on the right side, and turning the cloth then wiped the left groin area. It was noted that the wash cloth was stained yellow from feces. After wiping E15's groin, E18 took another cloth and wiped the outer labia which turned the cloth yellow from feces. E18 then cleansed R18's inner labia. The wash cloth was again yellow from feces. E18 then rinsed R15's peri area with a clean wet cloth; however, it too was noted to be yellow when E18 finished. E18 then cleansed R15's catheter tubing. E18 did not dry R15's peri area when finished. E18 did not ensure that R15's peri / vaginal area was fully cleansed of feces. E18 stated R15 had a bowel movement, and turned R15 to her left side. Both R15's buttocks and peri anal area were covered with sticky, yellow feces. E18 cleansed between R15's buttocks, and then cleansed R15's right outer buttock/hip area. E18 did not turn R15 or cleanse R15's left outer buttock/hip area. R18 then applied a barrier cream to R15 and then stated she was finished. On 5/27/09 a review of the facility policy Catheter Care, Urinary indicated #6 - Place bed protector under the resident, #7 - Wash the resident's genitalia and perineum thoroughly wit soap and water. Rinse the area well and towel dry.	F 315		

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F 319 SS=D	483.25(f)(1) MENTAL AND PSYCHOSOCIAL FUNCTIONING Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide adequate psychosocial interventions for one resident (R2) with recent history of suicide attempt in the sample of 24 residents. Findings include: R2 is 56 years old with partial diagnoses (from undated Cumulative Diagnosis Sheet) of: Suicide Attempt, Wound - Mouth; Major Depressive Disorder, Tracheostomy. R2's initial admission date is 12/3/08, with a readmission date of 4/29/09 following surgery to repair damage to his palate from the suicide attempt. During an interview with R2 on 5/12/09, R2 stated that he was bored; had no activities of interest to him, and he "mostly lay around in my room." R2 was asked if he has seen a psychiatrist since his admission to the facility. He replied he saw the psychiatrist once, approximately 4 or 5 months ago. R2 was asked if he attends any group meetings. R2 stated he attended group therapy while in the hospital and he felt he would benefit by therapy. R2 was asked if he talks to E26, Social Services Designee (SSD). He replied that he does not get along well with E26, would rather not talk to her.	F 319		

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F 319	Continued From page 95 R2's Care Plan dated 12/23/08, with update on 3/20/09, addressed a problem of: "(R2) attempted suicide before admission to this facility." The goal listed was to have no self harm attempts. R2's Social Service Notes were reviewed. The initial entry dated 12/12/08 stated (in part) that R2 was admitted for skilled nursing, and he was "adjusting well". The progress note written by E28, SSD assistant, stated R2 would be evaluated for further psychosocial assistance, monitored for mood and behavior. On 3/16/09, E28 documented in the Social Service note that R2 was noted to have sad facial expressions, and crying due to placement in nursing home and his wounds, low family contact. E28 listed behavior of "easily agitated", and behavior tracking sheets were on the unit to monitor behavior. E26, SSD, was interviewed on 5/14/09. E26 stated there were no psychosocial groups offered at the facility. E26 was asked if R2 was seeing a psychiatrist. E26 stated that R2 had seen Z2, Psychiatrist, once. E26 stated R2 had been sent out to another hospital for a psychiatric consultation but could not provide the date of the hospitalization. E26 was asked to provide the information from the psychiatric hospitalization. E26 could not find any psychiatric consultation or plan of care/discharge planning from the hospitalization. E26 stated, "it's probably in his purged file". E26 stated that the information should be kept in R2's current record. No documentation from R2's psychiatric hospitalization was provided by E26. R2's care plan was not updated to include information from the hospitalization, any new goals or interventions. E26 was asked if she screened R2 for	F 319		

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F 319	Continued From page 96 suicide risk. E26 stated, "I don't do any screening. Nursing does all the screening." E26 was asked about R2's care plan dated 12/23/08. E26 was asked how she was monitoring the goal of "Will have no self harm attempts". E26 stated, "He's on 1:1, and activities." E26 was asked if she asked R2 if he wants to harm himself. E26 stated, "I think I do." When asked where that information is documented, E26 stated, "It's on his calendar." R2's May calendar was reviewed. The calendar documented meetings on Friday. The subjects listed include: 5/1- Purpose of 1:1; 5/8 - Depression; 5/15 -Missing Wife; 5/22 - Going Thru Separation; 5/29 - Exercise to work with agitation. The calendar had no information about self-harm thoughts. Behavior tracking sheets for May were reviewed. The behaviors identified on the tracking forms are "Combative" and "Curses at Staff". The tracking form is filled out incorrectly, with + (plus) written daily under "outcome". E26 verified that staff was not correctly entering information on R2's behavior tracking form. There was no identified behavior regarding suicidal or self-harm thoughts. R2 stated in an interview on 5/14/09 that he felt he would benefit from and would attend group therapy if it was available.	F 319		
F 322 SS=E	483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		

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F 322	Continued From page 97 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview; the facility failed to provide tube feedings as ordered for one (R2) resident; failed to follow manufacture's directions for hang time for one (R11); failed to ensure proper infusion rate for one (R17); failed to follow facility's policy for flushing for one (R15), failed to provide dressing to gastrostomy sites as ordered for three (R17, R14, R15) in the sample of five residents receiving tube feedings. Findings include: 1. R2 is 56 years old with partial diagnoses (from undated Cumulative Diagnosis Sheet) of: Suicide Attempt, Wound - Mouth; Major Depressive Disorder, Tracheostomy. R2's initial admission date is 12/3/08, with a readmission date of 4/29/09 following surgery to repair damage to his palate from the suicide attempt. During initial tour on 5/12/09 at 10:20 AM, R2 was observed in his room. R2 had a tube feeding pole, pump, and open system tube feeding at his bedside. The bag was labeled "5/11/09, 90 cc/hour, Start 9 PM". There was approximately 1100 cc remaining in the tube feeding bag. R2 stated, "It's not working right. I didn't get any solution last night by tube. It doesn't do any good to put on my call light because nobody on night shift will answer the call light." During an interview at 2:30 PM on 5/12/09, R2 stated that he was able to eat mechanical soft food, in addition to the tube feeding. R2 stated he frequently experienced problems with the tube feedings. He stated the nurses "sometimes	F 322		

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F 322	Continued From page 98 forget to hook me up." R2 stated the tube feeding pump did not work correctly. He stated the pump's alarm sounded frequently. R2 stated, "One night, I hit the call light, they never answered it. I didn't get any response, so I just turned it off." R2 stated he has lost weight since admission to the facility. R2's December weight is recorded as 170.8 pounds. R2's April weight is recorded as 153.8 pounds, a weight loss of 17 pounds. Dietary/Nutrition Care Notes were reviewed. On 2/20/09, the Registered Dietician documented upgrading R2's diet to Mechanical Soft with Double Portions. There was no May weight available. 2.. Record review of R11's May 2009 POS, shows R11 is an 85 year old female who was admitted to the facility on 2-27-09 with a diagnosis, in part, Anemia, Dehydration and Feeding Disorder. POS shows an order for 39 cc's of Nutren 2.0 via G tube for 20 hours a day. Tube feeding is to be on at 10AM and off at 6AM. R11 also has an order for a Pureed Diet. Record review of R11's MDS of 3-29-09 shows R11 is totally dependent on staff for eating. R11's Care Plan of 3-5-09 states R11 is at risk for dehydration due to enteral feeding tube and decreased appetite and refuses to eat so g-tube was placed. R11 receives all nutrition and hydration via g-tube and receives pleasure feedings and fluids. R11 was observed during tour of the facility to be in bed at 10:20AM. R11's tube feeding was off and not connected. The tube feeding bag was dated with a hang time of 5-9-09 at 4AM. There was 500 cc's left in the 1500 cc bag. The	F 322		

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manufactures recommendation on the bag stated hang time is 48 hours at room temperature. The bag was hanging at room temperature. R11 was observed be up in her geriatric chair at 12:10PM in the Dining Room and remained in the chair until 2:17PM when she was transferred to bed. R11 still did not have tube feeding connected during this time even though order is for tube feeding to be on at 10AM. The bottle of formula that had been hanging during tour was gone. R11 was observed at noon meal and ate no pureed meat, 25% of plain mashed potatoes, 5% of pureed vegetables, no pureed apricots no pureed bread, a few sips of water and 75% of her red drink.

On 5-13-09, R11 was observed in bed at 12:05PM, R11's tube feeding was running at 39cc's an hour and the bag was dated 5-12-09 at 4:45 PM with rate documented at 39 cc's an hour.

R11 was observed on 5-14-09 at 9:10AM lying flat in bed and tube feeding not running. The tube feeding bag was dated 5-14-09 at 4AM and there was approximately 1325 cc's of feeding in the bag. R11 was observed at 10:20AM and 10:10AM and the tube feeding was not running. At 10:10AM the tube feeding was running and the alarm was sounding and the pump stated error.

3. Record review of R17's May 2009 POS shows R17 was admitted to the facility on 2-22-09 with an order for a no concentrated sweet diet and a tube feeding of Glytrol at 86 cc's and hour for 19 hours a day. Order states tube feeding is to be on at 12:30PM and off at 6:30AM. Flush G-tube with 90 cc's water every 4 hours.

R17 was observed on 5-12-09 at noon meal to get her tray at 12:59PM and she refused to eat. R17's tube feeding was not connected or

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F 322	Continued From page 100 running. R17 was observed on 5-13-09 at 12:30PM to be in the Dining Room and waiting for her noon meal. Her tube was not running. R17 again refused to eat. R17 was observed until 1:25PM, when E15, Registered Nurse, hung a new tube feeding bag. R17's g-tube site had a brownish green drainage and there was no dressing on the g-tube site. E15 confirmed the drainage and stated he would call the Physician. Nurses Note of 5-13-09 states G tube site observed with small amount of yellowish drainage and the Physician was notified. POS shows order of 5-13-09 for Keflex 500 mg per g tube three times a day. After antibiotic finished if no improvement in insertion site (g tube site) yellow drainage, consult GI. 4. Review of the ADMISSION SHEET identifies R14 as being a 58 year old female admitted to the facility 5/7/09 with diagnoses of Multiple Aneurysm and left craniotomy among others. The physician's order sheet indicates R14 had a gastrostomy tube feeding with Nutrin c Fiber ordered to run at 80cc per hour per pump in addition to a 150cc free water flush every 6 hours. The interim care plan failed to reflect the G-tube at all but does include a goal for to avoid dehydration with the goal reading "adequate hydration will be maintained x 21 days.". Intervention indicates staff are to "encourage fluid intake at meals and between", "If refuses fluids offer substitute", "monitor for causes of decreased intake, swallowing problem confusion, decreased thirst, etc and address accordingly" and monitor for signs/symptoms of dehydration. There is nothing regarding her NPO status and/or	F 322		

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F 322	Continued From page 101 her tube feeding. On 5/12/09 at 10am, R14 was observed to be in bed laying flat with her tube feeding (Nutren 2.0) running at 80 cc per hour per pump. E3, ADON (Assistant Director of Nursing) rolled R14 up. R14's g-tube insertion site was observed to have a moderate amount of thick sticky maroon-color drainage under the cap of the tube which had dried to her skin in some areas. The skin surrounding the g-tube insertion site was noted to be reddened as well. No dressing was observed on. E3 stated R14's site needed to be cleaned. The facility also failed to have a tracking mechanism in place to ensure that R14 receives the correct amount of formula daily as no Intake/Output sheets were used. The facility failed to provide needed services for R14's gastrotomy tube/feeding. 5. R15's Physician's order sheet dated 5/1/09 indicated a diagnoses in part of; Neurogenic Dysphagia, Hemiplegia, Parotis Left Face, and a Gastrostomy Tube (g-tube). Physician's order dated 5/1/09 indicated R15 is to have a g-tube flush of 200cc of water done each shift. The most recent Minimum Data Assessment indicated R15 is dependent on staff to assist with set up and monitoring of intake. On 5/13/09 at 11:35 AM, E25, Licensed Practical Nurse, flushed R15's g-tube. E25 assembled 200cc of fluid in plastic glasses and a 60cc syringe at R15's bedside. E25 began the flush by attaching the 60cc syringe to R15's g-tube and poured 60cc of the water into the tube and plunged/forced it into R15's stomach. E25 then stated, "I forgot to check placement, I don't	F 322		

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have a stethoscope, do you want me to go get one and check the tube?" E25 decided to stop and get a stethoscope. E25 then plunged 60 cc of air into R15's stomach and said "it sounds like it's (g-tube) in the right place." E25 then continued to plunge/force the remaining 140cc of water into R15's g-tube.

While E25 did the g-tube flush, R15 spoke up and stated "I have been waiting 4 days for them to come and flush my tube". Then holding up 4 fingers on her left hand she repeated, "they haven't done this for four days!" A review of the Medication Administration Record indicated that the g-tube flush was not listed from May 1 to May 13, 2009. E25 stated that she did not know what happened to the original sign off sheet, and that she had started a new one and signed off on the days that she had worked the flush had been done.

During the flush it was observed that the area around the insertion site was reddish and moist with a ring of dried debris noted around where the G-tube entered the abdominal wall. There was no 4x4 or dressing between the skin and the plastic disc holding the tube in place. E25 stated that it was the job of the treatment nurse to come and clean off the g-tube site, and offered to do it herself. After finishing the flush, E25 did not clean off R15's g-tube site.

A review of the facility "Maintaining Patency of a Feeding Tube (Flushing), Sept 2004, was reviewed. The policy indicated the g-tube should be checked for patency by injecting 10 to 30cc of air (not 60cc)into the tube and listening for sounds prior to adding fluids. The policy also indicated that water is to flow by gravity into the feeding tube.

On 5/14/09 at 9:10 AM in an interview with E7, Treatment Nurse, she stated the treatment nurse

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F 322	Continued From page 103 was not responsible for cleansing R15's g-tube site. E7 stated E25 was responsible to cleanse R15's g-tube sites either at the time of the flush or sometime during the shift. On 5/14/09 at 1:30 PM, E21, Licensed Practical Nurse, stated that on 5/13/09, E25 should have been responsible for caring for the g-tube site.	F 322		
F 323 SS=G	483.25(h) ACCIDENTS AND SUPERVISION 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: Based on observation, interview and record review, the facility failed to provide adequate supervision and progressive interventions to prevent falls for four (R9, R18, R23, R24) of 21 sampled residents. This failure resulted in the following: R23 falling, on 10/9/08, after being left unsupervised on the toilet. R23 sustained a nose fracture due to this incident; R23 fell on 4/21/09 and sustained a hip fracture; and R9 fell onto the floor with his restraint attached to his wheelchair on 3/20/09 and sustained a laceration to his nose requiring sutures. The facility failed to provide adequate supervision to prevent elopement for one (R28) of eight residents in the facility with a history of wandering. The facility failed to provide safe	F 323		

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transfer techniques for two (R10 and R15) of 10 sampled residents requiring the use of gait belts during transfers. The facility failed to provide safe hot water temperatures (from 100 degrees Fahrenheit (F) to 110 degrees F in areas accessible to residents.

Findings include:

1. R9's physician's order sheet, dated May 2009, documents he has partial diagnoses of Anxiety and Alzheimer's Disease.

The facility's Incident Report, dated 3/20/09, at 6:00 AM, noted he was found on the floor with a wheelchair on top of him with a soft belt still intact. He had a laceration to his nose. He was sent to the hospital and received sutures to his nose. The Recommendation/Interventions listed "will place front and back anti tippers on w/c (wheelchair)".

R9's care plan, dated 3/20/09, noted "Res has a soft self release waist restraint. Res had hx (history) of falls. Has had no falls since soft restraint." The approaches documented "Staff to release soft waist restraint during meals and when in full view of staff". R9's care plan was not updated to address the fall, on 3/20/09, or the restraint.

R9's Quarterly Restraint Effectiveness Report, dated 12/20/08, noted the reason for the use of the soft waist physical restraint was "falls-unaware of his own safety". There was no documentation on this report regarding if any attempts had been made to use a less restrictive measures or R9's response to those measures. This report did not indicate the risks versus benefits of using a soft waist restraint. Furthermore, this report did not indicate the medical need for the restraint. After R9 fell on

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F 323	Continued From page 105 3/20/09, the facility did not reassess the appropriateness of the soft waist restraint or the risks versus benefits of using this restraint. On 5/12/09, at 10:28 AM, R9 was in a geriatric recliner with a soft waist restraint in the therapy room. E21, Licensed Practical Nurse, noted he was in the geriatric recliner due to he was Hospice and had experienced a decline in condition. On 5/12/09, at 11:35 AM, R9 was in the main dining room in the geriatric recliner with the soft waist restraint. Staff fed R9 his lunch and he remained in the dining room until 1:30 PM, at which time he was placed in his room. At no time, did the staff remove R9's waist restraint during the meal. On 5/13/09, at 8:34 AM, E10, Certified Nurse's Aide (CNA), was feeding R9. R9 remained reclined in his geriatric chair with his soft belt restraint throughout the meal. On 5/14/09, at 9:13 AM, E22, Certified Nurse's Aide noted "Sometimes he (R9) slides down in his chair and we have to pull him up. When he was in his wheelchair, he would try to get up. Sometimes we would see him trying to make his bed. He doesn't do that anymore, he has had a decline." The facility did not reassess for the appropriateness of the soft waist restraint after R9 was placed in the geriatric chair. The facility did not update the care plan to implement new interventions with regards to this restraint. 2. R18 was admitted on 4/8/09. R18's physician's order sheet, dated May 2009, noted she had a right hip fracture. R18's nurse's note, dated 5/11/09, at 4:00 PM, documented "To residents room after	F 323		

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hearing personal alarm. She had moved herself to end of bed and was attempting to get over side rail into wc (wheelchair). Did not use call light. 'I can do this myself'. Alarm secured. Resident witnessed moving alarm. Redirected. "

R18's nurse's note, dated 5/19/09, at 2:45 AM, R18 fell while trying to get up out of bed." NEED MORE INFORMATION!!!!!!

On 5/14/09, at 4:25 PM, R18 was lying in her bed. She had full side rails up on both sides of the bed. Again, at 10:03 AM, and again at 10:50 AM, R18 was lying in bed with full side rails up on each side of the bed.

R18's Minimum Data Set, dated 4/21/09, noted she had "other types of side rails used (e.g. half rail, one side)".

R18's Side Rail Assessment, dated 4/8/09, noted she had right and lift side rails to serve as an enable to promote independence. The assessment indicated there was no risk to R18 if the side rails were used. Furthermore, the assessment documented the side rail/alternatives/interventions did not create more risks than side rail use. This assessment does not indicate a medical necessity for the use of full side rails.

The facility did not reassess R18's full side rails for the risks versus benefits of their use after she attempted to climb out of the bed. The facility did not attempt to less restrictive alternatives prior to using full side rails on R18's bed.

The facility had no care plan regarding the use of the restraint. The facility did not implement progressive interventions to address R18 attempting to exit the bed with the side rails up.

3. R28 was admitted to the facility on 4/24/09. His physician's order sheet, dated May 2009,

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documented he had the following diagnoses: Dementia, Depression, Hydrocephalus, and History of Stroke.

The facility's incident report, dated 5/20/09, documented R28 did not go to the dining room to eat his lunch. E29, Licensed Practical Nurse (LPN), told E1, Administrator, and E2, Director of Nurse's she had searched for R28 but she could not find him. E29 indicated she had last seen R28 at 11:30 AM. E1 and E2 initiated an immediate search inside the facility, outside the facility and the local area. The police were notified. E2 searched for R28 in her vehicle. At 1:15 PM, E2 found R28 near the downtown area of the city. R28 had no injuries due to his elopement. The incident report indicated R28 had been wearing a resident monitoring device that morning; however, he was not wearing the resident monitoring device when he was found.

On 5/20/09, at 2:00 PM, R28 was sitting in the lobby. R28 responded "I was going home", when questioned regarding leaving the facility. R28 noted he was going home to get his wife. He noted it was warm outside. He indicated the facility is "too confined for me". He noted he requires little help from the staff at the facility.

R28's Elopement Assessment, dated 4/25/09, documented he had a score of 10. The Assessment indicated if the score was 5 or greater, the resident was at risk for elopement.

R28's Minimum Data Set (MDS), dated 5/7/09, documented he had some short-term memory loss and had some difficulty making decisions in new situations only. The MDS noted he could ambulate independently. However, the MDS did indicated he had an unsteady gait.

R28's social service notes, dated 4/26/09, 4/28/09, 5/9/09, documented the social service director replaced R28's monitoring device due to

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F 323	Continued From page 108 it came off or R28 took it off. R28's nurse's notes, dated 4/26/09, at 5:00 PM, noted "Resident was outside smoking, resident began to the leave the premises was caught by the activity aide. This nurse spoke c (with) resident and told resident that he can not the premises for his safety". R28's nurse's notes, dated 4/28/09, at 2:00 PM, noted R28 was walking outdoors without supervision. R28 was brought back into the facility without incident. R28's nurse's note, dated 5/9/09 documented "Res out front door c three plastic bags. went over to (check) on resident et (and) he stated 'I'm going home'. Alarm not on res - CNA stayed with res while I went back in to call wife - wife stated that Res is now (and) was not in the future leaving to go home (sic) - Res was call to phone to speak to wife - When he got off phone stated 'Oh, I must have been mistaken. I'm not going home today'. Took bags back to room". On 5/20/09, at 1:25 PM, the surveyor drove to the location R28 was found. R28 was found approximately 2 miles from the facility. The speed limit was 30 miles per hour. There are sidewalks located on each side of the street. The street is heavily traveled by automobiles. 4. On 5/14/09, at 10:16 AM, in Room 501, the hot water temperature was taken at the sink in this room with a digital thermometer. The temperature was 115.6 degrees Fahrenheit (F). On 5/14/09, at 10:20 AM, in the 300 hall shower room, the hot water temperature was taken at the sink and was 115.2 degrees F. On 5/14/09, at 10:30 AM in the 400 hall shower room, the hot water temperature was taken at the sink ans was 114.4 degrees F. On 5/14/09, at 10:52 AM, in Room 203, the hot water temperature was taken at the sink and	F 323		

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F 323	Continued From page 109 was 115.4 degrees F. On 5/14/09, at 10:56 AM, in Room 219, the hot water temperature was taken at the sink and was 114.9 degrees F. On 5/14/09, at 10:15 AM, E42, Maintenance Supervisor, indicated there a boiler that feeds hot water to the entire building. E42 indicated hot water temperatures are taken daily in various rooms and around the same time every day. 5. R10 was observed during initial tour of the facility on 5/12/09. At 11:45 AM, R10 was observed seated in a wheelchair in the dining room, with her head lowered. As she raised her head, she had deep purple facial bruising around both eyes. Both eyes were purplish-black with lacerations noted on both eyebrows. The dark purple bruising extended down her face, into her neck and upper chest region. R10's left arm was bruised, around the entire arm, near her left elbow. R10's right index finger was deep purple around the entire finger, from knuckle to finger tip. R10 was asked how she hurt herself and replied, "I had a bad fall a couple weeks ago." Z4, R10's brother, was seated beside her in the dining room and stated that she had actually had two falls recently, causing the facial injuries. R10's chart was reviewed. Her April 2009 Physician's Order Sheets listed partial diagnoses of: Right Hand Fracture, 3rd, 4th, 5th Metacarpals; Congestive Heart Failure, Diabetes Mellitus Type II, Multiple Contusions, Osteoporosis, Abnormal Gait; Obesity, Arthritis. R10's May 2009 Physician's Order Sheet contained orders for two antipsychotic medications: Haldol 2.5 mg. P.O. (by mouth), TID (three times daily) and Q (every) 4 hours PRN (as needed); Prochlorperazine (Compazine) 5 mg. P.O. every morning and 4	F 323		

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times daily as needed. R10's order for Prochlorperazine was initiated on 1/31/09. The order for Haldol was initiated on 5/1/09.

The facility's fall/incident reports for R10 were reviewed. R10's Nursing Notes dated 5/4/09 documented that at 9:10 AM, R10 stood up while out on the patio and fell before staff could reach her. The Nursing Note stated R10 was sent to the hospital, diagnoses with "fracture of face."

Nursing Notes dated 5/5/09 at 12:20 AM, stated R10 "took self to BR (bathroom) & slipped down to floor. Hit her head, left eyebrow lacerations. Steri strips (3) applied.....Will monitor."

The facility's fall/incident reports and investigations for the falls on 5/4/09 and 5/5/09 were reviewed. The 5/4/09 incident stated new interventions listed to prevent further falls was, "Position near N.S. (nurses station) for better observation. Plan of action: 1. Not to go outside without assistance. 2. Taken out for fresh air with AT (Activity Therapy) weekly. 3. Receptionist to get assistance if she goes outside.

The facility's report and investigation for 5/5/09 fall in R10's bedroom is classified as "Self-inflicted". The investigation stated the fall was an "unassisted transfer to the toilet,... taking herself to BR, slipped and fell." The new intervention following this fall was to place a bed alarm on the bed; use a self-release seat belt in the wheelchair.

The facility's investigation form includes a section "Medications that could have contributed (to the fall): Norvasc, Metoprolol, Ativan." There was no mention of the newly-prescribed Haldol, or Prochlorperazine prescribed on 1/31/09. There was no mention of the anti-anxiety drug Xanax. There was no mention of recent changes from Ativan to Xanax on the incident investigation

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form.

R10's current MDS dated 3/13/09, assessed R10 having short-term memory problems, no long term memory problems; with modified independence in cognitive skills for daily decisions for daily decision making, some difficulty in new situations only. R10's fall risk assessment was dated 9/11/08, with no quarterly assessments since September. R10's Care Plan is dated 12/20/07, with the most recent update noted on 9/18/08. R10's care plan describes that "R10 makes complaints that someone is "out to get her"...Resident is nearly blind and family believes resident is paranoid and making false accusations. Resident refused to take any psychotropic meds or mood stabilizers. Res. has repetitive health and non-health complaints." There was no update following the initiation of Haldol or Prochlorperazine.

R10's most recent fall risk assessment is dated 9/11/08, with a score of 10. Total score of 10 or above represents HIGH RISK. There is no update after 9/11/08. R10's Care Plan in the chart is dated 8/13/07. This care plan is the interim care plan which is present on all resident's charts at the time of admission. There was no specific problem and plan for R10's high risk for falls. There are no progressive interventions for R10 following falls with injury.

6. R24's record was reviewed as a closed record. R24's original admission date is 2/25/09. He was transferred from another nursing home. R24's Physician's Order Sheet for April 2009 listed partial diagnoses of Renal Insufficiency, Anemia, Failure to Thrive, Urinary Tract Infection, Cataracts, Hypertension; Cerebral Vascular Accident.

R24's initial siderail assessment is dated

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F 323	Continued From page 112 2/25/09. The assessment is incomplete, with some questions not answered. The questions "Does the resident have a history of falls, Is there evidence the resident has or may have a desire or reason to get out of bed?" are both blank. The questions: "Is there a risk to the resident if siderails are used?" is answered NO. There is no risk versus benefits assessment listing the potential risks of using siderails for R24. R24's accident/incident reports and investigations documented skin tears of unknown oriens on 3/4/09, 3/10/09, 4/10/09, 4/27/09, and 4/29/09. On 4/6/09 at 12:30 AM, R24 was discovered to have bruising of his right upper arm and chest, near the axilla. Nursing notes documented a dark purple bruise 7 - 8 centimeters round. X-ray of right ribs obtained on 4/8/09 documented lower lobe infiltrate and old healed fracture of the eighth rib. R24 had a large bruise to his right neck and shoulder, origin unknown, on 4/9/09. There is no re-assessment of the siderails to determine if the siderails could have caused the skin tears or bruises. The risk versus benefits failed to inform of potential risks of injury caused by use of siderails. 7. R23's record was reviewed as a closed record. R23's Minimum Data Set (MDS) dated 9/12/08 assessed R23 required extensive assistance of staff for transfer, walking in room and corridor, and toilet use. On 10/8/08 at 12:30 AM, R23 was found on the floor of his bathroom, holding a towel to his nose. R23 was sent by ambulance to the emergency room and found to have a fractured nose. The investigation for this incident contains a care plan for R23 attached to the investigation dated 9/11/09. The care plan stated (in part), "At	F 323		

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risk for falls related to decreased vision r/t recent cataract surgery on 10/1/08. On 10/8/08, he had taken himself to the bathroom...raised toilet seat came off toilet and resident fell forward to the floor.....noted laceration to anterior portion of nose." (Note discrepancy in dates)

The interventions listed on the investigation included "Educate staff not to leave alone on toilet."

From 10/22/08 through 3/21/09, R23 had six additional falls. He was found on the floor of Activity Room twice, found on the floor of the dining room twice. The investigation for the 3/21/09 fall stated there was a new intervention of "Waist restraint applied to chair. Staff reminded to use seat belt." No obvious injuries were noted.

On 4/5/09, at 11:25 AM, R23 was found on the floor of the hallway/lobby area with his wheelchair on top of him. Seat belt is still attached, alarm sounding. New intervention for this incident was to send him out for psychiatric evaluation and treatment of agitation.

On 4/14/09, R23 was readmitted to the facility. On 4/15/09, at 6:00 PM, R23 was found on the floor of the dining room. The investigation stated R23 may have been attempting to self-ambulate. The interventions included medication review and possible increase in Xanax, to scheduled three times daily instead of PRN (as needed). There was no obvious injury noted.

On 4/16/09, at 4:00 AM, R23 was discovered on the floor of the Activity Room. The investigation stated there were no obvious injuries noted. The investigation did not indicate why R23 was in the Activity Room unsupervised at 4:00 AM.

On 4/16/09 at 11:05 AM, R23 fell out of his wheelchair while "reaching for something on the

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F 323	Continued From page 114 floor". He sustained skin tears to both hands. The intervention listed was an alarm, and 1:1 supervision to monitor. On 4/21/09 at 4:00 AM, R23 was found on the floor of his room. R23's left foot was rotated inward. He was complaining of pain in his left hip and knee. R23 was sent by ambulance for evaluation and treatment. R23 was admitted to the hospital with a fractured left hip. The facility's investigation and report to IDPH stated that R23 would be evaluated by therapy for "weakness." The facility's Policy and Procedure for Falls dated 1/1/09 stated residents at high risk for falls will be further screened by PT (Physical Therapy) and OT (Occupational Therapy). R23 had four falls since re-admission on 4/15/09. He was not referred to PT and OT until the fall resulting in a fractured hip on 4/21/09. 8. On 5/13/09 at 9:30 AM, a review of R15's physician's order sheet indicated a diagnosis in part of Hemiplegia, and Neurogenic Dysphagia. The most recent Minimum Data Set dated 4/20/09 indicated R15 is a one person assist for transfers and all activities of daily living. On 5/12/09 at 2:26 PM, E18, Certified Nurses Aide assisted R15 to bed. E18 pulled R15 up along side of the right side of the bed in her wheel chair. E18, locked the wheels and then assisted R15 to stand, turn, and sit / lay down on the bed. E18 did not use a gait belt when assisting R15 to transfer. On 5/13/09 at 9:40 AM, in an interview with E31, Occupational Therapy Aide, she stated that due to R15's medical problems, R15 was weak and unstable on her feet, needed staff assistance to stand and transfer, and staff should use a gait belt when standing or transferring R15.	F 323		

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F 323	Continued From page 115 A review of the facility policy Transferring Residents from Chair to Bed, indicated staff are to "apply gait belt" before moving the resident.	F 323		
F 325 SS=G	483.25(i) NUTRITION 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, interview and record review, the facility failed to ensure 2 (R1, R16) of 24 residents on the sample, and 1 resident, (R34) off the sample, have individualize nutritional needs assessed and received a diet as ordered. This failure resulted in harm to R16 who had a significant weight loss of 9.3 % in 2 months and who was complaining of being hungry and begging for food. Findings include: 1. Record review of R16's May 2009, Physician Order Sheet, POS, shows R16 was admitted to the facility on 2-27-09 with a diagnosis, in part, Failure to Thrive, Reflux Esophagitis and Anemia. POS shows an order for a regular pureed diet with yogurt at meals and at HS, bedtime. POS shows an order dated 3-25-09 for health shakes	F 325		

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F 325	Continued From page 116 3 times a day with meals. Record review shows no cancellation of this order. R16 Minimum Data Set, MDS, of 3-12-09 identifies R16 as being totally dependent on 1 staff for eating. Is 5'4" tall and weighs 113 lbs. (pounds). MDS states R16 leaves 25% or greater at meals. MDS states daily supplement between meals, yet Physician Orders and Dietary Notes do not reflect she receives supplements between meals, only at night. MDS shows R16 has moderate pain daily. R16's Care Plan of 3-13-09 states under Problems, " R16 has no chewing due to loss of teeth. She does not like the type of foods offered she will only eat yogurt. She is use to a lot of fried foods at home and the "old south ways of cooking" and she will tell you that she can't eat that but if you bring her some yogurt or something sweet she will eat it." Care Plan approaches include the following; give pain medication as ordered; assist during meals as she cannot feed herself; assist with fluids to prevent dehydration; assist to make dental appointments as requested; provide diet and food consistency as ordered by Physician (see current physician order sheet for current diet and consistency). provide total mouth and dental care after each meal; teach resident importance of correct and daily oral hygiene; offer substitutes per resident request; give resident foods of choice as she request them if they are available. NUTRITIONAL ASSESSMENT of 3-3-09 shows R16 weight was 113 lbs with Ideal Body Weight is 120 +/- 10% (108 - 132 lbs.) Assessment states own teeth with few/missing teeth. Assessment shows R16 Yeates 25% to 75% of food served. Assessment note states R16 is a frail thin female admitted to the facility .	F 325		

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F 325	Continued From page 117 Under weight per BMI, Basal Metabolic Index, and history of weight loss of greater 80 lbs overall. Fair to poor meal intake. May benefit from appetite stimulant, was given Periactin prior. Recommend additional med pass 60 cc's QID, four times a day. Consider appetite stimulant. (The facility provided a Memo from the Dietitian form dated 3-3-09 with above recommendation. A note dated 3-25-09 states Hospice was called at 11:00AM. The area on the memo for MD Response is blank and the space for Physician Signature is left blank. There is nothing in R16's Nurses Notes addressing the above recommendation. DIET ORDER & COMMUNICATION of 3-16-09 shows an order for house supplement, Registered Dietitian Consult needed and states R16 likes Super Cereal. DIET ORDER & COMMUNICATION OF 4-9-09 states regular pureed diet with yogurt with all meals and HS, bedtime snack and 60 cc's of med pass with meals. (There is no other notes from the Registered Dietitian until 5-18-09.) Laboratory tests of 4-2-09 show a low hemoglobin of 10.2 (normal is 12-16 g/dl) and a low hematocrit at 29.6 (normal 37 -47%) and low total protein of 5.0 (normal 6.1 to 7.9 g/dl and low albumin at 2.4 (normal 3.5 - 4.8 g/dl.). R16 was observed on 5-12-09 at 11:45AM, at noon meal, to be sitting in the Dining Room in a wheel chair waiting for her tray. R16 looked very thin, almost emaciated. R16 stated she wanted to go to bed stating she hurt. At, 12:40PM, R16 was still at the Dining Room table complaining of pain and still had not been served her meal. The nurse stated she had just given R16 a Vicodin. At 12:45PM, E1, Administrator, was observed to take R16 out of the dining room and stated R16 says her back hurts and she doesn't want to eat	F 325		

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anything. R16 had still not been served any food or fluids and had been sitting at the table for at least 1 hour per observation.

On 5-13-09 at 11:50AM, R16 was observed to be sitting at the Dining Room in a wheel chair waiting for her noon meal. R16 stated she was so sick. Her neck hurts all the time stating it hurt all the way down to her spine. R16 stated she just wanted to go to bed. R16 stated, "Please let me go to bed." R16 was moaning and grimacing and had no food or fluid at the table. At 11:59AM to 12:22PM, R16 still had no food or fluids. At 12:30PM, R16 got a pureed diet with yogurt. There was no health supplement or shake on her tray. R16 was observed to feed herself yogurt and take a few bites of pureed meat.

On 5-15-09 at 11AM, R16 was in bed lying down. R16 stated, "I want something to eat. I'm hungry. I want some yogurt. If I could just have a cup of yogurt." E16, CNA, came into the room and stated R16 doesn't eat much. She complains of being hungry all the time. R16 again asked for yogurt and a piece of candy. E16 stated R16 likes her sweets. During skin check, R16 stated it hurts when she moves and stated she could hardly roll over. E16 did bring R16 yogurt. At 12:35PM, R16 was observed to be in bed
eating yogurt. Her lunch tray had not been touched and again, there was no house supplement or shake on her tray. R16's tray card did not have House Supplement or shake at meals or the fact that R16 liked super cereal. Record review of the Pureed menus show super cereal is not on the menu.

Record review of facility Weight Report Form for 3-1-09 - 5-1-09 shows, R16 weighted 113 lbs on 3-1-09 and was down to 102.4 lbs. R16 was weighed on 5-15-09 at around 1:30PM per

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F 325	Continued From page 119 request. E33 and E34, Restorative CNA's were observed to weigh R16 on the Mechanical Sling Lift scale which showed R16 weighed 122.7 lbs. At 2PM, E33 stated that she and E34 are the one who weigh R16. E33 stated they both agreed that there was no way that R16 weighed 122.7 lbs or that she looks like she has gained weight. Interview with E1 and E2 on 5-21-09 reflected they had problems with the mechanical sling scale and they would call in the manufacturer to look at the scale. Registered Dietitian note of 5-18-09, states order of 5-18-09 to discontinue health shakes and to give med pass 2.0, 120 cc's with each med pass. Note states visited with R16 who would be happy to get 2 yogurts with meals. Note identifies above labs but gives no plan to increase albumin / total protein, such as, adding protein powder to foods, R16 will eat or super cereal which is fortified with protein. Note of 5-25-09 states weight 5/09 is 118.6 lbs. a 5.5% increase in 1 month. (Observation of R16 during skin check showed R16 was very thin and could not weigh 118.6 lbs.) There is no assessment or plan to try to provide foods to R16, that she will eat other than yogurt. There is no assessment as to if R16's pain may be cause of lack of appetite. 2. Record review shows R34 was admitted to the facility on 5-11-09 with an order for a low cholesterol, limited concentrated sweet, low fat diet at regular consistency. R34 stated on 5-12-09 at 12:25PM, she hadn't had anything to eat since admission to the facility yesterday. R34 stated the only thing she has had was water. R34 stated she couldn't eat due to sores in her mouth. R34 opened her mouth which showed beet red sores. R34 stated the	F 325		

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F 325	Continued From page 120 previous night she was sent a regular tray with pea soup. She did not eat the pea soup because she does not like it. R34 stated she didn't eat anything at breakfast, she did not get a tray. She stated she had a hamburger on her tray today at lunch, but couldn't eat it due to the sores in her mouth. She said the CNA was going to bring her some broth. E12, CNA, was observed to bring a bowel of broth to R34. E12 was asked if R34 had breakfast and E12 stated no, R34 said she didn't get any breakfast. Record review of R34's Admission Nursing Assessment or Nurses Notes showed there was nothing in the notes about R34's sore mouth and not being able to eat regular consistency food. 3. Review of the MDS dated 3/10/09 identifies R1 as being a 79 year old female readmitted to the facility on 8/12/08 with diagnoses of Decubitus Ulcer of lower back, heel and calf, Contractures, Parkinson's Disease, Arthropathy, and Cerebral Vascular Accident among others. The MDS indicates R1 has short/long term memory deficits with severe cognitive impairment and totally dependent on staff for all activities of daily living including eating. The MDS has no indicators for fluid status identified. R1's current physician's order sheet indicates she is to receive a no added salt, pureed diet with thin liquids, supercereal at breakfast and pudding with lunch and dinner. The care plan interventions include providing her diet, hand feeding and offer alternate food choices for dislikes. Review of her weights shows a gradual decline in weight from January, 09 at 87.9 pounds to 82.3 pounds in April. The May weight was 94.4 pounds with no reweigh noted on the weight sheet. The RD quarterly note dated 4/30/09 indicates no change	F 325		

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F 325	Continued From page 121 recommended. R1 is currently on Hospice. On 5/13/09 at 12;15pm, R1 was observed being fed her lunch by E8, CNA. R1 had no pudding on her tray as ordered by the physician and her milk was unopened. R1's butter pat also remained unopened. E8 stated R1 won't drink her milk as she doesn't like it. She eats only her main entree. The facility failed to follow physician's orders by providing the pudding at lunch. The facility failed to implement R1's care plan by not offering providing substitutes for food uneaten and for the milk with E8 states R1 dislikes. Interview with R1' family member on 5/15/09 indicates she is not fond of the pureed food. This is not reflected in the RD notes as well.	F 325		
F 327 SS=E	483.25(j) HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide adequate fluids during care and at the bedside for four (R1,R9,R13, R15) of 21 sampled residents; and the facility failed to provide complete intake and output records for two (R11 and R15) of two sampled residents with gastrostomy tubes and indwelling catheters. Findings include: 1. R9 was admitted to the hospital on 4/9/09 with a partial diagnosis of Dehydration. R9 was readmitted to the facility on 4/15/09. On 4/17/09,	F 327		

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F 327	Continued From page 122 his physician ordered a pureed diet with nectar thickened liquids. On 5/12/09, R9 received nectar thickened liquids at lunch. He drank 50% of his fluids at this meal. At 1:30 PM, R 9 was in his room. There was a water pitcher in his room filled with unthickened water. On 5/12/09, at 1:50 PM, E21, Licensed Practical Nurse and E18, Certified Nurse's Assistant, assisted R9 into bed. E21 and E18 confirmed R9 had not been incontinent when they removed his adult diaper. Both confirmed he had been dry since they got him up for breakfast. At no time did E21 or E18 provide R9 with thickened fluids. On 5/13/09, at 9:10 AM, R9 was lying in bed asleep. There was a water pitcher full of unthickened water at his bedside. R9's Minimum Data Set, dated 3/20/09, noted he required extensive assistance with eating. His care plan, dated 3/20/09, had not been updated to address his hydration needs or his needs for thickened liquids. 2. Record review of R11's May 2009 Physician Order Sheet, POS, shows R11 has an order for a Tube Feeding and a Urinary Catheter. Record review of Policy and Procedure for Urinary Catheters, provided by the facility as their most recent policy, states, facility would monitor Intake and Output, I&O. Record review of R11's Care Plan of 3-5-09 shows R11 is at risk for Dehydration, is on a Tube Feeding and has a Urinary Catheter. There is nothing in the Care Plan reflecting the facility monitoring R11's I&O. Interview with E2, Director of Nursing, on 5-14-09 confirmed the facility failed monitor R11's	F 327		

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F 327	Continued From page 123 I&O. 3. Review of the MDS (Minimum Data Set) dated 3/24/09 identifies R13 as being an 80 year old female readmitted to the facility on 3/28/08 with diagnoses of Nephritis, Hemiplegia, Hematuria and Hypertension among others. The MDS indicates R13 has short/long term memory deficits with moderate cognitive impairment and requires extensive assist of staff for most activities of daily living. The MDS has no indicators for fluid status identified. The Physician's Order Sheet, POS, shows R13 receives the diuretic Lasix 20mg daily along with Docusate Sodium 100mg twice daily.. The care plan identifies fluid needs under pressure ulcer prevention and indicates staff are to encourage fluid intake on all shifts. Review of the Registered Dietician note, dated 4/30/09 identifies R13's daily minimum fluid needs as 2700cc/24 hours. The laboratory section indicates R13 has a history of UTI's (urinary tract infection) on 1/21/09, 9/2/08, 7/22/08 and 7/8/08 all culturing E. Coli >100,000 col. and an elevated BUN of 34 (normal 8-20). On 5/12/09 at 11:33am, R13 was in her wheelchair in the beauty shop. At 12:10pm, R13 was taken directly to the dining room where she independently ate lunch and drank 100% of her coffee and water. No additional fluids were offered or provided. At 1:12pm, R13 was back in her room at bedside. Her water pitcher was not within reach. R13 was observed at 1:25pm, 1:30pm, 1:35pm and 1:40pm to remain at bedside in her wheelchair with no fluids within reach. At 2:10pm, R13 was transferred to bed by E6, CNA (certified nurses aide). E6 failed to offer or encourage fluids during care. On 5/13/09 at 9:38am, R13 was again observed to be in her wheelchair at the foot of the	F 327		

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F 327	Continued From page 124	F 327		

bed. No fluids or call light were within reach. At 11:22am, R13 was in activities and at 12:30pm, was eating her meal in the dining room. R13 ate independently after her tray was set up. She drank no water and only some of her coffee. She did not finish her supplement.

The facility failed to identify R13 at risk for fluid deficits, failed to implement her care plan by providing /encouraging fluids at meals and in between with care.

4. Review of the MDS dated 3/10/09 identifies R1 as being a 79 year old female readmitted to the facility on 8/12/08 with diagnoses of Decubitus Ulcer of lower back, heel and calf, Contractures, Parkinson's Disease, Arthropathy, and Cerebral Vascular Accident among others. The MDS indicates R1 has short/long term memory deficits with severe cognitive impairment and totally dependent on staff for all activities of daily living including eating. The MDS has no indicators for fluid status identified. Review of the RD's annual assessment dated 8/28/08 indicates R1's daily minimum fluid requirement is 1200cc. The physician's order sheets (POS) indicate R1 receives Dulcolax every other day. The care plan fails to reflect R1's hydration needs alone however, does identify staff intervention which states "staff to offer extra fluids during daily care and repositioning and prn (as needed)." The care plan also identifies R1 to be at risk for UTI's with staff encouraging liquids at meals and between meals. R1 had contractures of both hands.

On 5/12/09 at 2:30pm, R1's skin was checked and she was turned at that time. R1 had ice water at bedside but no fluids were offered with care by E6, CNA.

On 5/13/09 at 9:28am, E6, CNA, turned R1

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F 327	Continued From page 125 and no f luids were offered with care. At 12:26pm, R1 was being fed her lunch by E8, CNA. R1 had only a carton of unopened milk on her tray which E8 stated she wouldn't drink because she didn't like milk. At 1:07pm, Z1 and E7, treatment nurse came in to do R1's dressing change. No fluids were offered with care. On 5/14/09 at 11:20am, E9 and E10, Restorative Aides entered R1's room to weigh her using the mechanical lift. No fluids were offered with care. The facility failed to ensure that R1 take adequate fluids and failed to implement R1's care plan which states staff with provide and encourage fluids with meals, with care and in between meals. 5. R15's Physician's order sheet dated 5/1/09 indicated a diagnoses in part of; Neurogenic Dysphagia, Hemiplegia, Parotis Left Face, Gastrostomy Tube (g-tube) and Catheter. Physician's order dated 5/1/09 indicated R15 is to have a g-tube flush of 200cc of water done each shift. The most recent Minimum Data Assessment indicated R15, has swallowing problems, has a mechanically altered diet, and is to have staff assist with meal set up and monitoring of intake. A review of R15's physician's order sheet dated 5/1/09 indicated R15 was to have a Mechanical Soft / Regular diet with nectar thickened liquids. On 5/12/09 at 12:30 PM, R15 was served a mechanical soft tray with two glasses of nectar thickened fluids. The fluids were milk 120cc, and cranberry juice 120cc. On 5/13, and 5/14, R15 was served the same two glasses of 120cc each fluids. Observation of R15's room indicated no pitcher or cups of thickened fluids were available.	F 327		

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F 327	Continued From page 126 Intermittently, throughout the survey, when R15 was observed in her room, no staff were noted to offer her fluids. On 5/15/09 at 10:00 AM, R15 indicated that she usually got fluids at meals, med pass, or g-tube flush. Further review of R15's record failed to indicate that R15's intake and catheter output (I/O) were being monitored. On 5/20/09 at 10:00AM, in an interview with E21, Licensed Practical Nurse, she stated that residents I/O's were only monitored the first one or two weeks in the facility, after that unless the resident was having a problem the I/O was noted in the nursing notes. A review of R15's nursing notes indicated intermittent (not daily) monitoring of her catheter output or fluid intake. A review of the facility policy Urinary Catheter Care, indicated the following: #7 - Maintain an accurate record of the resident's daily output, per facility policy and procedure. On 5/20/09 at 11:00 AM, E2, Director of Nursing, stated staff should be actively monitoring I/O for residents with catheters, and oral intake issues. E2 stated she was not aware that staff did not actively track the I/O of R15, and other resident's with catheters and / or special intake issues. E2 stated that she would be writing a policy for staff to maintain accurate I/O in the future.	F 327		
F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning;	F 328		

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F 328	Continued From page 127 Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview; the facility failed to provide proper tracheostomy care for the only resident in the facility with a tracheostomy (R2) in the sample of 24. Findings include: R2 is 56 years old with partial diagnoses (from undated Cumulative Diagnosis Sheet) of: Suicide Attempt, Wound - Mouth; Major Depressive Disorder, Tracheostomy. R2's initial admission date is 12/3/08, with a readmission date of 4/29/09 following surgery to repair damage to his palate from the suicide attempt. During initial tour on 5/12/09 at 10:20 AM, R2 was observed in his room. R2 had a tracheostomy with a dark brown stain on the trach collar. On 5/12/09 at 2:30 PM, R2 stated, "I usually clean it myself. Most of the time, the trach doesn't get cleaned at all. It's dirty now. I don't think they're getting trach kits to change it." On 5/13/09, at 2:15 PM, E29, Licensed Practical Nurse (LPN) entered R2's room to clean his trach. E29 opened the trach care tray and placed it on R2's uncovered overbed table. There was a small glass bottle of sterile water on the overbed table as well as the trach tray. E29 opened the kit and attempted to shake apart the sterile gloves that were inside the trach tray. The sterile gloves were stuck together. E29 pulled the sterile gloves apart with her fingers,	F 328		

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F 328	Continued From page 128 contaminating the sterile gloves. E29 placed a sterile drape on R2's chest, looked around and stated, "I have no peroxide." R2 reached into his drawer for peroxide, touching the sterile drape which fell to his lap as he leaned over. E29 placed the drape back onto R2's chest and poured hydrogen peroxide into the container from the trach kit. R2 dipped the pipe cleaners into the peroxide and cleaned the inner cannula. Foam was noted inside the cannula. R2 stared at the closed container of sterile water on R2's overbed table and stated, "If I touch that, it's contaminated." R2 wiped the cannula with dry gauze and placed it back into the stoma without rinsing the peroxide from the cannula. R2 wiped the stoma, dried the neck around the stoma, placed a split 4 x 4 gauze around the stoma and attempted to replace the trach collar. E29 asked, "Am I putting it on backwards?" R2 requested E29 tighten the trach collar. After discarding the trash, E29 stated that the trach is changed daily, usually on evening shift. The facility's policy and procedure for tracheostomy care was reviewed. The procedure stated (in part) that the tube was to be soaked in hydrogen peroxide for ten (10) minutes; cleaned with pipe cleaners and a brush; rinsed and dried. The procedure stated that aseptic (sterile) technique must be used.....sterile gloves must be used during aseptic procedures. The procedure stated that trach care must be provided at least twice daily for old, established trach sites; and once a shift for new tracheostomies.	F 328		
F 329 SS=G	483.25(l) 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	F 329		

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F 329	Continued From page 129 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview; the facility failed to assess for medical reasons for increasing agitation and confusion for one (R10) , failed to provide justification, appropriate psychiatric diagnosis, targeted behaviors, and monitoring for use of anti-psychotic medication for three (R10, R3, R20) residents in the sample of 24. This failure resulted in a two falls with significant injuries to R10 on 5/4/09 and 5/5/09; three days after antipsychotic medication (Haldol) was initiated for R10. Findings include:	F 329		

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1. R10 was observed during initial tour of the facility on 5/12/09. At 11:45 AM, R10 was observed seated in a wheelchair in the dining room, with her head lowered. As she raised her head, she had deep purple facial bruising around both eyes. Both eyes were purplish-black with lacerations noted on both eyebrows. The dark purple bruising extended down her face, into her neck and upper chest region. R10's left arm was bruised, around the entire arm, near her left elbow. R10's right index finger was deep purple around the entire finger, from knuckle to finger tip. R10 was asked how she hurt herself and replied, "I had a bad fall a couple weeks ago." Z4, R10's brother, was seated beside her in the dining room and stated that she had actually had two falls recently, causing the facial injuries.

R10's chart was reviewed. Her April 2009 Physician's Order Sheets listed partial diagnoses of: Right Hand Fracture, 3rd, 4th, 5th Metacarpals; Congestive Heart Failure, Diabetes Mellitus Type II, Multiple Contusions, Osteoporosis, Abnormal Gait; Obesity, Arthritis.

R10's May 2009 Physician's Order (PO) Sheet contained orders for two antipsychotic medications: Haldol 2.5 mg. P.O. (by mouth), TID (three times daily) and Q (every) 4 hours PRN (as needed); Prochlorperazine (Compazine) 5 mg. P.O. every morning and 4 times daily as needed. R10's order for Prochlorperazine was initiated on 1/31/09. The order for Haldol was initiated on 5/1/09.

R10's May 2009 PO Sheet documented orders for anti-anxiety medication, Xanax, 0.5 mg. Q 8 hours PRN. A physician's order dated 5/1/09 stated, "D/C (discontinue Xanax. Start Haldol 2.5 mg. P.O. TID (three times daily) and Q 4 hours PRN. Hold if sedated."

The facility's fall/incident reports for R10 were

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reviewed. R10's Nursing Notes dated 5/4/09 documented that at 9:10 AM, R10 stood up while out on the patio and fell before staff could reach her. The Nursing Note stated R10 was sent to the hospital, diagnoses with "fracture of face."

Nursing Notes dated 5/5/09 at 12:20 AM, stated R10 "took self to BR (bathroom) & slipped down to floor. Hit her head, left eyebrow lacerations. Steri strips (3) applied.....Will monitor."

The facility's fall/incident reports and investigations for the falls on 5/4/09 and 5/5/09 were reviewed. The facility's investigation form includes a section "Medications that could have contributed (to the fall): Norvasc, Metoprolol, Ativan." There was no mention of the newly-prescribed Haldol, or Prochlorperazine prescribed on 1/31/09. There was no mention of the anti-anxiety drug Xanax. There was no mention of recent changes from Ativan to Xanax on the incident investigation form.

R10's current MDS dated 3/13/09, assessed R10 having short-term memory problems, no long term memory problems; with modified independence in cognitive skills for daily decisions for daily decision making, some difficulty in new situations only. R10's fall risk assessment was dated 9/11/08, with no quarterly assessments since September. R10's Care Plan is dated 12/20/07, with the most recent update noted on 9/18/08. R10's care plan describes that "R10 makes complaints that someone is "out to get her"...Resident is nearly blind and family believes resident is paranoid and making false accusations. Resident refused to take any psychotropic meds or mood stabilizers. Res. has repetitive health and non-health complaints." There was no update following the initiation of Haldol or Prochlorperazine. There was no

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identification of targeted psychotic behaviors. There is no psychiatric diagnoses that justified the use of any antipsychotic medications.

Z3's hospice progress notes were reviewed. Hospice Notes dated 4/28/09 documented under Breath Sounds, R10 had "Rales - Right base, posterior." Z3 described R10 as "anxious, c/o nervousness." Z3 reported edema in bilateral lower legs, 3+ and 4+. Z3 notes a primary diagnosis of CHF. There is no documentation of pulse oximeter readings to rule out hypoxia as the cause of nervousness and agitation.

Hospice notes dated 4/30/09 documented rales, right upper and lower posterior lobes. The oxygen saturation was noted at 97% on room air. R10 is noted with "Dyspnea with moderate exertion". R10 is noted to have 3+ and 4+ edema, bilateral lower legs with a note "unable to palpate pedal pulses r/t edema". There are no new orders to address the edema or absent pedal pulse r/t edema.

Hospice notes dated 5/4/09 document R10's fall. She is described on the nurse visit note as "drowsy". Edema 4+ is documented on bilateral lower extremities. There is no documentation of pulse oxygen saturation levels.

On 5/6/09, Hospice notes documented rales, dyspnea with moderate exertion. Wounds to R10's face are described as "Excessive bruising et (and) swelling. Right laceration, sutured. Left scabbed." R10 is described as "lethargic". Bilateral edema 3+ and 4+ documented. Pulse oxygen saturation levels are not documented.

On 5/7/09, a new Hospice Care Plan for "delirium" is noted. R10 is described as "picking at air, body, and floor. Cannot get to focus on nurse or respond to questions....leaning over in w/c for objects not present." There is no

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F 329	Continued From page 133 documentation of R10's respiratory system, "unable to assess, pt too agitated with delirium." Edema 4+ is noted in bilateral lower legs. Visit note dated 5/7/09 documented (in part): "bruising to entire face, neck. Laceration - scabbed; Laceration - sutures intact." Z3 documented, "Pt. more cooperative today, still having hallucination. Unable to focus in on nurse when spoken to. Looks around to see where voice is coming from." R10's Care Plan dated 3/10/09 documented that R10 is "almost blind". On 5/8/09, a new Hospice Care Plan for "confusion" is added. The observation is "remains increasingly confused. Hallucinating, less agitated." There is no specific "hallucination" described. R10's hospice visit note noted as previously documented, "unable to palpate pedal pulses r/t edema". Edema is 3+, bilateral lower legs. On 5/19/09 at 11:30 AM, Z3, Hospice Nurse, was interviewed by telephone. She stated that R10 was admitted to hospice care on 3/12/09. The admitting diagnoses for hospice was "Debility unspecified." Z3 stated she wrote the physician's orders for the Haldol on 5/1/09. Z3 stated the medication was prescribed to address behaviors of increasing confusion, increasing agitation. Z3 stated R10 was "real agitated, real confused. We were unable to control...(R10)." Z3 stated the hospice physician, Z4, was called for telephone orders. Z3 could not state if Z4 had ever seen R10 since hospice care started on 3/12/09. Z3 was asked if all R10's medications were reviewed when hospice assumes care. Z3 stated she did review medications. When Z3 was asked about the psychiatric diagnoses to justify the addition of Haldol, Z3 stated, "Do you mean I can't prescribe Haldol for agitation?" When	F 329		

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F 329	Continued From page 134 asked why R10 was on the antipsychotic medication, Prochlorperazine (Compazine), Z3 asked, "Is that an antipsychotic medication? I didn't know that Compazine was an antipsychotic." The Geriatric Dosage Handbook, 12th Edition, by Todd P. Semla, PharmD, BCPS, FCCP; Judith L. Beizer, PharmD, CGP, FASCP; and Martin D Higbee, PharmD, documented Special Geriatric Considerations for both antipsychotic medications, ppg. 725 and ppg. 1297, "Many older adult patients receive antipsychotic medications for inappropriate nonpsychotic behavior. Before initiating antipsychotic medication, the clinician should investigate any possible reversible cause; any stress or stress from any disease can cause acute "confusion" or worsening of baseline nonpsychotic behavior. Most commonly, acute changes in behavior are due to increases in drug dose or addition of a new drug to regimen; fluid electrolyte loss; infectons; and changes in environment. Any changes in disease status in any organ system can result in behavior changes....." 2. R3 is 79 years old with diagnoses (from May 2009 Physician's Order Sheet) of: Alzheimer's, Increased Confusion, Hypertension, Debility unspecified. R3's Physician's Order Sheet contained a current order for the anti-psychotic medication Risperdal 0.5 mg. daily. R3's current MDS is dated 3/20/09. He is assessed as totally dependent on staff for bed mobility, transfer, dressing, eating, hygiene, bathing, toilet use. R3's current care plan updated on 3/19/09 stated that R3 is "unable to assist staff.....minimal to extensive assist...Unable to make needs known r/t	F 329		

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F 329	Continued From page 135 dementia..." There is no problems on R3's care plan to address use of psychoactive medications. There is no psychiatric diagnoses to justify the use of the anti-psychotic medication, Risperdal. There is no "targeted behavior" specified for the use of antipsychotic medication. There are no documented behaviors noted, other than resistive to care. R3 was observed frequently during the survey, on 5/12/09, 5/13/09, 5/14/09. R3 was unable to move himself in bed, remained motionless unless moved by staff. R3 was fed all meals by staff during the survey. On 5/19/09, the facility presented information stated R3 was admitted to the facility on the medication. The facility stated R3 was on the medication d/t "dementia with combativeness." 3. Review of the MDS dated 2/20/09 identifies R20 as being readmitted on 11/17/08 with diagnosis of Acute Renal Failure, Diabetes Mellitus, Hypertension and Osteoarthritis. The MDS indicates R20 requires extensive assist of one staff for all activities of daily living. The MDS indicates R20 has short term memory deficits and decision making concerns in new situations. The MDS doesn't identify any behaviors or mood concerns. Review of the POS (Physician's Order Sheet) indicates R20 is receiving Zyprexa 5mg at bedtime. Review of the care plan shows no behavioral concerns even though R20 is receiving Zyprexa. Review of the BEHAVIORAL SYMPTOM EVALUATION quarterly reassessments dated 11/25/08, 9/2/08, and 6/2/08 indicates R20's identified behaviors was resisting care, not wanting to lay down, and not wanting to elevate legs. The intensity scale is at 4-5 (most intense -	F 329		

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F 329	Continued From page 136 10) and no new interventions are identified. The BEHAVIOR SYMPTOM EVALUATION sheet dated 3/10/08 identifies Depression and resisting care as well. The description of the problem states "res (resident) has episodes of resisting care not wanting to take meds, elevate legs, and anxious complaints at times." The intensity scale identifies at "4" with 10 being the highest. Other factors identified indicate R20 is alert and oriented times three and is able to change her behaviors. The facility failed to have justification for use of the Zyprexa and failed to develop a plan to address her refusals of medication and elevating her legs given that she is able to make her own decisions. Review of the NURSING HOME VISIT NOTES dated 4/15/09 lists "Psychosis, on Zyprexa, ..." but no indication as to why this diagnoses was added is evident. Throughout the survey, R20 was observed to be in her wheelchair. On 5/15/09, R20 indicated she did not like to have her legs elevated and does have pain at times which is controlled with medication when she asks for it. There is no evidence the facility has developed a plan to address her refusals of care in an effort to increase compliance.	F 329		
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS 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, interview and record reviews the facility failed to follow it's policies for medication administration. This error resulted in two (R25, R39) off sampled residents receiving	F 332		

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medication at the wrong time, and one (R30) resident to receive a discontinued medication. A total of 46 opportunities were observed with a total of 4 errors. This error resulted in a medication error rate of 8.6%.

Findings include:

1. On 5/12/09 at 1:10 PM, E25, Licensed Practical Nurse, gave Ativan 1mg / tablet, to R39. A review of the physician's order dated 5/6/09 indicated; Ativan 1mg / by mouth / 9:00 AM and 9:00 PM. A review of the Medication Administration Record indicated that the order had been writen correctly, but then had been changed to 1:00 PM. On 5/12/09, E25 stated that she did not know how the order had become changed on the MAR. On 5/14/09 at 1:00 PM, E2 Director of Nursing stated "I think the order got changed because R39 wanted to take the medicine at 1:00 PM instead of 9:00 AM, however I have to ask the nurses, who made the change. Throughout the rest of the survey no additional information was given regarding this order or why it was changed.

2. On 5/12/09 at 4:47 PM, E24, Registered Nurse, gave Flovent Inhaler, 2 puffs to R30. On 5/13/09, a review of R30's physician's orders indicated that the Flovent had been discontinued on 4/21/09. A review of R30's Medication Administration Record indicated that the order for Flovent had not been discontinued.

On 5/13/09 E15, Registered Nurse,on the 400 hall, stated that he had called R30's physician and verified that the Flovent wassupposed to have been stopped on 4/21/09, however nursing staff had continued to give the medication. E15 stated that he would notify E2, Director of

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F 332	Continued From page 138 Nursing, of the medication error. 3. On 5/13/09 at 10:08am, E4, LPN (Licensed Practical Nurse) administered R25 Reglan 5mg 1/2 tab with her other medications including 5cc of Nystatin Swish and swallow. Review of the physician's order sheet indicates R1's Reglan was ordered at 6am. The Nystain was ordered to be given at 9am, 1pm and 5pm. At 11:35am, E5 poured up R25 1pm dose of Nystatin 5cc and proceeded to leave the cart to give it to R25. The surveyor intervened and told E5 that R25 had just received her last dose at 10:08am. E5 stated she didn't realize she had just gotten it then, looked at the MAR (Medication Administration record) and stated she could wait to give it later since it was actually ordered for 1pm. The facility failed to ensure that medication were ordered according to physician's orders.	F 332		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal	F 334		

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F 334	Continued From page 139 representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.	F 334		

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F 334	Continued From page 140 (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to follow their Policy and Procedure to provide education and offer influenza and pneumococcal immunizations for 7(R4, R9, R8, R11, R15, R16 and R21) of 21 sampled residents.. Findings include: Record review of facility Policy and Procedure for immunizations shows residents and or representative would be provided education on influenza and pneumococcal immunization and immunization would be provided unless resident of representative refused. Record review of residents medical record immunization tracking form shows the following residents did not receive education and immunization for influenza and /or pneumococcal as per policy; R4, R8, R9, R11 R15, R16 and R21. Interview with E2, Director of Nursing, on 5-20-09 confirmed there was no information the facility could provide showing the above residents were educated and receive the influenza and/or pneumococcal immunization.	F 334		

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F 353 SS=E	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide proficient staff to provide the following care and services: provide adequate privacy and dignity; restraint usage; prevent abuse; answer call lights timely; provide resident equipment which meets the needs of the residents; feed residents timely; provide meaningful activities per resident's assessments; limit noise in resident use areas; provide adequate pain management; coordinate services for Hospice and Dialysis; provide adequate incontinent, oral and hygiene care;	F 353		

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F 353	Continued From page 142 provide treatment and services to prevent pressure ulcers; provide adequate incontinent care and toileting to prevent urinary tract infections and maintain bladder function; provide proper treatment and service for residents with gastrostomy tubes; provide adequate nutrition; provide adequate hydration; provide complete tracheostomy care; ensure a medical diagnoses for residents on psychotropic medications; ensure an accurate and timely medication pass; provide supervision to prevent accidents; and provide a system to prevent infections including handwashing and aseptic techniques. 1. F164: Based on observation and interview the facility failed to provide privacy during care for two (R1 and R8) of 21 sampled resident, and two (R30 and R42) off sampled residents. 2. F221: Based on observation, interview and record review, the facility failed to identify a medical need and assess the risks versus benefits for the use of restraints for five (R4,R9,R15,R18 and R24) of five sampled residents with restraints. This failure resulted in R9 falling to the floor with his wheelchair and soft waist restraint attached to him. R9 sustained a laceration to his nose. He was sent to the hospital and received sutures. 3. F225: Based on observation, interview, and record review the facility failed to investigate and report to the Department, an allegation of possible physical abuse for one (R8) resident in the sample of 21 . 4. F241: Based on observation, interview and record review, the facility failed to ensure residents do not have to sit for extended time	F 353		

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F 353	Continued From page 143 before receiving their food for four (R5,R9,R16 and R17) and two expanded sampled residents (R42 and R45) during two meal observations; and failed to promote dignity of one (R31) expanded sampled exposing herself; and failed to promote dignity by maintaining clothing in good condition for two (R8 and R15) of 21 sampled residents. 5. F246: Based on observation, record review, and interview; the facility failed to answer call lights timely and have call lights accessible for three (R1, R2, R41); failed to accommodate resident preferences for awakening and bedtime for six (R5, R47, R48, R49, R50, R52, R32); failed to offer showers regularly for one (R33), failed to serve meals timely to numerous dependent residents while other residents were eating; failed to remove soiled meal trays timely for one (R7); failed to provide appropriate resident equipment for one (R1, R13) of 24 sampled residents and seven off-sample residents. 6. F248: Based on observation, interview and record review, the facility staff failed to assess and provide meaningful activities for four (R2,R3,R6 and R11) of 21 sampled residents and one (R32) expanded sampled resident. 7. F258: Based on record review and interview; the facility failed to address residents' complaints of noise levels. 8. F309: Based on observation, record review and interview, the facility failed to have an accurately assess and monitor pain management for five (R16,R13,R1,R18 and R9) of 10 sampled residents; the facility failed to follow an order for a	F 353		

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F 353	Continued From page 144 fluid restriction for one (R7) of three sampled residents on a fluid restriction; the facility failed to ensure coordination of care for two (R1, and R10) of four sampled residents receiving Hospice; the facility failed to provide coordination of care for one (R21) sampled resident receiving dialysis; the facility failed to provide accurate and individualized interim care plans for four (R14,R22,R23,R21) of 24 sampled residents. 9. F312: Based on observation and record review, the facility failed to provide adequate oral care for one (R1) of 21 sampled residents; failed to provide adequate grooming of nails and facial hair for three (R1,R6 and R9) of 21 sampled residents and one (R43) expanded sampled resident; failed to provide complete incontinent care for one (R3) of seven sampled residents who were incontinent of urine. 10. F314: Based on observation, record review and interview, the facility failed to have a system in place for pressure sore prevention, identification, assessment, and treatment for 9 (R1, R6, R7, R9, R11,R13 ,R14,R15, R17, R18, and R20) of 24 sampled residents. This failure resulted in harm to R17, who developed an avoidable facility acquired Stage 2 pressure ulcer on the coccyx that decline to a Stage 3. In addition, R17 developed an avoidable facility acquired Stage 2 pressure ulcer on the right hip. This failure resulted in harm to R7 who developed four Stage 2 avoidable facility acquired pressure ulcers that the facility failed to identify, assess and treat. This failure resulted in harm to R13, who developed a facility acquired Stage III pressure ulcer on the right heel which declined to an unstageable pressure ulcer. This failure resulted in harm to R1, who developed a	F 353		

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F 353	Continued From page 145 Stage III pressure ulcer which increased in size and is currently an unstageable pressure ulcer. This failure resulted in harm to R18, who developed a facility acquired avoidable Stage III pressure ulcer to her buttocks. 11. F315: Based on observation, interview and record review, the facility failed to provide incontinent care in a manner which prevents urinary tract infections for three (R11, R20 and R15) of seven sampled residents requiring incontinent care; the facility failed to encourage and offer toileting per plan of care for two (R13 and R20) of five sampled residents on a toileting program. 12. F322: Based on observation, record review, and interview; the facility failed to provide tube feedings as ordered for one (R2) resident; failed to follow manufacture's directions for hang time for one (R11); failed to ensure proper infusion rate for one (R17); failed to follow facility's policy for flushing for one (R15), failed to provide dressing to gastrostomy sites as ordered for three (R17, R14, R15) in the sample of five residents receiving tube feedings. 13. F323: Based on observation, interview and record review, the facility failed to provide adequate supervision and progressive interventions to prevent falls for four (R9, R18, R23, R24) of 21 sampled residents. This failure resulted in the following: R23 falling, on 10/9/08, after being left unsupervised on the toilet. R23 sustained a nose fracture due to this incident; R23 fell on 4/21/09 and sustained a hip fracture; and R9 fell onto the floor with his restraint attached to his wheelchair on 3/20/09	F 353		

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F 353	Continued From page 146 and sustained a laceration to his nose requiring sutures. The facility failed to provide adequate supervision to prevent elopement for one (R28) of eight residents in the facility with a history of wandering. The facility failed to provide safe transfer techniques for two (R10 and R15) of 10 sampled residents requiring the use of gait belts during transfers. The facility failed to provide safe hot water temperatures (from 100 degrees Fahrenheit (F) to 110 degrees F in areas accessible to residents. 14. F325: Based on observation, interview and record review, the facility failed to ensure 2 (R1, R16) of 24 residents on the sample, and 1 resident, (R34) off the sample, have individualize nutritional needs assessed and received a diet as ordered. This failure resulted in harm to R16 who had a significant weight loss of 9.3 % in 2 months and who was complaining of being hungry and begging for food. 15. F327: Based on observation, interview, and record review, the facility failed to provide adequate fluids during care and at the bedside for five (R1,R9,R13, R15 and R3) of 21 sampled residents; and the facility failed to provide complete intake and output records for two (R11 and R15) of two sampled residents with gastrostomy tubes and indwelling catheters. 16. F328: Based on observation, record review, and interview; the facility failed to provide proper tracheostomy care for the only resident in the facility with a tracheostomy (R2) in the sample of 24.	F 353		

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F 353	Continued From page 147 17. F329: Based on observation, record review, and interview; the facility failed to assess for medical reasons for increasing agitation and confusion for one (R10) , failed to provide justification, appropriate psychiatric diagnosis, targeted behaviors, and monitoring for use of anti-psychotic medication for three (R10, R3, R20) residents in the sample of 24. This failure resulted in a two falls with significant injuries to R10 on 5/4/09 and 5/5/09; three days after antipsychotic medication (Haldol) was initiated for R10. 18. F332: Based on observation, interview and record reviews the facility failed to follow it's policies for medication administration. This error resulted in two (R25, R39) off sampled residents receiving medication at the wrong time, and one (R30) resident to receive a discontinued medication. A total of 46 opportunities were observed with a total of 4 errors. This error resulted in a medication error rate of 8.6%. 19. F441: Based on interview and record review, the facility failed to implement an infection control program to identify and monitor infections for all residents in the facility; and the facility failed to provide an aseptic technique when completing dressing changes for one (R8)of 12 sampled residents with pressure ulcers . 20. F442: Based on observation and record review the facility failed to follow it's policies for isolation for one (R15) resident with infections of C-Diff and MRSA, in the sample of 21 residents. 21. F444: Based on observation and record review, the facility failed to ensure staff remove gloves and wash their hands after giving care to	F 353		

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F 353	Continued From page 148 3 (R11, R17, R13 and R20) of 21 in house sample residents, and 1 (R32) expanded sampled resident.	F 353		
F 364 SS=D	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to prepare pureed food in manner which maintained the nutritive value for 13 residents in the facility receiving pureed food; and the facility failed to provide food which is served at a palatable temperatures at the time of meal service during one meal observation. Findings include: 1. On 5/13/09, at 10:18 AM, E32, Cook, began to prepare the pureed food for the lunch meal. She placed 13 one-fourth cup servings of chicken and noodles into a food processor. She added a large undetermined amount of hot chicken broth to the the chicken and noodles and pureed the mixture. The mixture was runny. The pureed chicken and noodles tasted bland. At 10:27 AM, E32 began to prepare the chicken fried steak. She placed 13 steaks and several cups of hot chicken broth into the food processor and pureed the mixture. The chicken fried steak was extremely salty. The facility's recipe for pureed chicken and noodles called for less than 2 cups of chicken	F 364		

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F 364	Continued From page 149 broth to be added to the chicken and noodles. The facility's recipe for pureed chicken fried steak called for 15 tablespoons of chicken broth. 2. On 5/13/09, at 10:00 AM on 5/13/09, during the group interview, nine of nine residents noted the food is always served late and is cold on a routine basis. On 5/13/09, at 12:37 PM, a test tray was obtained and the food was tested with a thermometer and tasted. The mechanical fried steak was 130 degrees Fahrenheit, and tasted luke warm. The chicken and noodles were cool to the taste.	F 364		
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the chlorine chemical sanitizing dishwasher was effectively sanitizing dishes, utensils, and food contact equipment during dish washing for one breakfast meal observation; the facility failed to prevent potential contamination of food-contact surfaces and cooked foods during the preparation of pureed food during one meal observation; the facility failed to store food in a manner to prevent	F 371		

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F 371	Continued From page 150 potential contamination in the freezer, refrigerator and dry food storage; the facility staff failed to prepare food in a manner which would protect the food from potential contamination. Findings include: 1. On 5/13/09, at 10:25 AM, after preparing the pureed food for lunch, E32, Cook, took the food processor container and placed it in the dishwasher. During the dish washing process, a chlorine chemical test strip was used to test the concentration of the chemical sanitizer (if effective, the test strip would turn light purple to medium purple indicating 50 parts per million) in the dishwasher. The chlorine chemical test strip remained white, indicating the dishwasher was not dispensing any chlorine chemical sanitizer. E35, Dietary Employee, noted he did not test the dishwasher with a chlorine chemical sanitizing strip prior to doing the morning dishes to ensure the dishwasher was working properly. E35 indicated the last time the dishwasher was tested was the evening prior. E35 confirmed most of the breakfast dishes had been washed. E36, Dietary Manager, confirmed the chlorine sanitizing dishwasher was not dispensing any chlorine. E36 noted she would have to call the dishwasher company. At 10:27 AM, E32 took the non-sanitized food processing container and began to puree the chicken fried steak. While pureeing the chicken fried steak, E32 grabbed a cloth from the dirty sanitizing bucket. The cloth dripped dirty water onto the cooked chicken fried steak on the baking pan. E32 then wiped down the food processing container and lid while pureeing the chicken fried steak. At 10:41 AM, E32 indicated the sanitizing bucket was filled with water and chlorine. A	F 371		

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F 371	Continued From page 151 chlorine test strip was dipped into the bucket. The test strip remained white, indicating the bucket did not have enough chlorine to effectively sanitize food contact surfaces. 2. On 5/12/09, at 9:58 AM, during the initial tour of the kitchen, in the freezer, two boxes of cookies were open to air. The top layer of cookies in the box were covered with frost. One uncovered pan of cherry dessert was on the top shelf of the freezer. The dessert was covered with frost. Two food boxes were on the floor of the freezer. On 5/12/09, at 10:03 AM, in the walk-in refrigerator, there was three cookie sheets containing bowls of dessert which were not covered to prevent potential contamination. On 5/12/09, during the initial tour of the kitchen, in the dry storage room, there was a package of spaghetti which was opened to the air. 3. On 5/12/09, during the lunch meal, from 11:45 AM until 12:45 PM, E37, Director of Activities, was cooking brautwurst and hamburgers on the grill without wearing a hair net.	F 371		
F 431 SS=F	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		

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F 431	Continued From page 152 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record, the facility failed to follow pharmaceutical policies regarding storge and refrigeration of medications; the facility failed to ensure the medication storage areas are maintained clean and free of food items in twoof two medication rooms; the facility failed to ensure insulins and expired medications are discarded as necessary for seven (R37,R58,R38,R35,R32,R53,R30) expanded sampled residents; the facility failed to ensure all medications are appropriately labeled with the correct resident name for one (R7) of 21 sampled residents and one (R53) expanded sampled residents ; the facility failed to provide	F 431		

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F 431	Continued From page 153 thermometers to ensure appropriate temperatures for refrigerators storing medications in one of two medication rooms; and the facility failed to ensure all stock and emergency medication boxes are locked and dated in two of two medications rooms. 1. On 5/20/09 at 2:55 PM the 300/400 hall med room was observed with E40, Registered Nurse, and found to have the following: The small upper refrigerator containing insulins and medicines was 52 degrees. At 3:26PM it the temperature was taken and found to be 48 degrees. In the small medication refrigerator, R7 and R53 both had a brown bottle labeled Novolog 100 Insulin. However when the vial inside the bottle was checked, R7 and R53's insulins were in the wrong containers. R7 was in R53' container and R53 was in R7's container A bag, with R54's name on it contained 6 Ativan 1mg vials stored in refrigerator. Inside the bag 1 vial was opened, with no start date written on it. The lower larger refrigerator containing resident foods was 42 degrees and also contained a open cup of soda brought in by a staff member, and various condiments jars that were opened, that staff brought in for personal use. A Spireva Inhaler and three Combivent inhalers were laying open on a shelf with no names on them. An inhaler labeled with R7's name lay loose on	F 431		

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F 431	Continued From page 154 the shelf. A box with numerous medications for R32, R54 and R55, was on a lower shelf. E40, Registered Nurse, stated the box was medications being stored for residents in the hospital. It was noted that R32 is a current resident. An opened box with several packages Ipatropine Bromide 0.2% sat in a corner on top of the sink counter. There was no name on the medications. E40 indicated that these were medications sent via mail order to residents in the facility. E40 did not know which resident used them. An IV tray with several opened and half used Heparin / Lidocaine ampules lay on a top shelf. None of the vials were dated as to when first used. A box of mail order medications for R32 was on a lower shelf. Mixed in with R32's medications were the medications of another resident R57, Ranexa tabs. E40 stated that R57 was no longer a resident in the facility but could not recall when she left. The Emergency kit was unlocked with expired medications... Ampicillin Injection 1.5gm x1 expired May 1, 2009 Ceftazidine 1 gm Injectable / Expired May 1,2009, Tobramycin 80mg / 2ml expired on Jan 2009. E40 stated that the pharmacist usually comes to check the emergency boxes once a month, but could not say the last time pharmacist had come to check the box. The 300 hall Medication cart was observed at	F 431		

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F 431	Continued From page 155 1:00 PM on 5/20/09, the following medications were found to be opened and expired on the cart. R37 - one vial Lantus Insulin opened 4/17/09, and one vile Novolog opened 4/4/09 R58 - one vial Lantus Insulin opened 4/3/09 R38 - one vial Novolog Insulin opened 4/13/09 R35 - one vial Novalog Insulin opened 2/9/09 The 400 hall Medication cart was observed at 1:30 PM on 5/20/09, and the following medications were found to be opened and expired on the cart. One stock bottle Diphenhydramine caps, expired 4/2009 R32 - one vial Novolog Insulin opened 4/17/09 R53 - one vial Novolog Insulin opened 4/2/09 R30 - one vial Lantus Insulin opened 4/17/09 A review of the facility policy for storage of medications indicated Lantus Insulin and Novolog Insulin, are considered to expire 28 days after opening. 2. On 5/14/09 at 10:40am, the front hall medication room within the nurses station was observed Review of the pharmacists review sheets dated 1/23/09 identify concerns as followed: 1) cleaning and organization are needed, 2) lab supplies and/or specimens cannot be stored in the same refrigerator with pharmaceuticals,.... There is no evidence the reports were acted upon. The report dated 4/28/09 show no mention of the front medication room. There is no evidence the pharmacists followed up to concerns voiced in January, 2009. On 5/14/09 at 10:40am, the front hall medication room within the nurses station was observed The med room had two refrigerators in it. One was located on the shredder machine	F 431		

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F 431	Continued From page 156 and was noted to have a urine specimen in a plastic bag laying on top of a bag of intravenous fluids. The refrigerator had various other injectables and suppository medications in it. It had no thermometer in it. The floor and shelves of the refrigerator were soiled as well. On top of this refrigerator was a used empty cake pan. This frig also had numerous cards of medications on top of it which staff identified as a discharged resident's medication. The other refregerator was sitting directly on the floor. It had a bag of IV solutions in it along with 1/2 drank plastic cups of soda, yogurt containers and other edible items. None of which were dated or identified. The refrigerator had large areas of spilled tan solutions on the walls and floor which had dried. The thermometer registered 48 degrees. There was also a box of contraceptives. The cupboards were also noted to be disorganzied with two shelves having discharged residents medication sitting on them. The convenince medication box was sitting on a shelf and had a 1/2 eaten container of food on it. The box was opened with no date on it. The ADON (Assistant Director of Nursing) came shortly afterwards and stated she didn't know the medication room looked liked this as she was attempting to pick it up.	F 431		
F 441 SS=F	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual	F 441		

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F 441	Continued From page 157 resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement an infection control program to identify and monitor infections for all residents in the facility; and the facility failed to provide an aseptic technique when completing dressing changes for one (R8)of 12 sampled residents with pressure ulcers . Findings included: 1. On 5/19/09, the facility provided a folder of infection reports for the last year. The infection reports noted the residents name, symptoms, if a culture was obtained, doctor notification and specific antibiotics if ordered. However, the facility had no method of tracking specific infections or identifying trends in infections. The facility had no method to identify if the antibiotics were effective. There was no documentation indicating if follow-up cultures were needed. There was no documentation regarding if diagnostic test were obtained and what were the results. On 5/19/09, 3:20 PM, E2, Director of Nurse's, noted she had been employed at the facility for approximately one month. She indicated she was not aware of any method or program the facility had for monitoring and tracking infections. 2. On 5/13/08, a review of R8's physician's order sheet indicated he has a diagnoses in part	F 441		

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F 441	Continued From page 158 of; quadriplegia, chronic pain, and multiple chronic decubitus ulcers. On 5/13/09 at 2:00 PM E7, Registered Nurse and E23, Licensed Practical Nurse performed dressing changes to R8's pressure areas on his buttocks. At the start of treatment, E7 was looking for the bandage scissors to cut clean dressings with. After looking through the top drawer of the treatment cart, E7 asked E23 if she knew where the scissors were. E23 pulled a pair of scissors out of her uniform pocket and handed them to E7. E7 took the scissors but did not clean them before she began cutting strips of bandaging tape and clean 4x4's used for dressing R8's pressure ulcers. At 2:15 PM, during the dressing change, E23, handled the clean dressings and tape with her bare hands. At one point E23 was seen to wipe her eye and brush her hair with her right hand and then resume handling R8's clean dressings. At this time E7 noticed E23 was not wearing gloves, and prompted her to put gloves on before continuing to handle the clean dressings and tape. E23 did not wash her hands after touching herself.	F 441		
F 442 SS=D	483.65(b)(1) PREVENTING SPREAD OF INFECTION When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to follow it's policies for isolation for one (R15) resident with infections of C-Diff and	F 442		

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F 442	Continued From page 159 MRSA, in the sample of 21 residents. Findings include: 1. R15's Physician's order sheet dated 5/1/09 indicated a diagnoses in part of; Neurogenic Dysphagia, Hemiplegia, a Gastrostomy Tube (g-tube), MRSA of Nares and Urine, and C-Diff in her Stool. The most recent care plan dated 4/20/09 indicated R15 was on isolation precautions for MRSA and C-Diff. On 5/14/09 at 1:40PM E21, Licensed Practical Nurse, provide G-tube care and a flush to R15. E21 stated that R15 was on isolation precautions due to C-Diff and MRSA. E21, put on gloves and removed the 4x4 gauze that was covering R15's g-tube site. The 4x4 was stained with a small amount of reddish pink drainage. R15 opened the red isolation bin with her gloved hand and then closed the lid with her gloved hand. E2 did not change her gloves, and began to wash off R15's g-tube site with soap and water from the room faucet. E21 did not have enough cloths to rinse and dry R15's g-tube site. E21 took her gloves off and holding them in her hand, E21 went out into the hall to get more cloths from the hall linen cart. Upon returning to the room, E21 put the dirty gloves she was holding into the red isolation cart, closing the lid with her hand. E21 did not wash her hands, but put on another set of gloves and proceeded to rinse off the site, dry it, and apply a clean 4x4 to the skin around the g-tube. When completed, E21 stated she was going to flush the g-tube site. E21 did not wash her hands or put on clean gloves for this procedure. E21 picked up a empty container and filled it with water for the flush. E21 completed the flush without gloving or washing her hands prior to	F 442		

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F 442	Continued From page 160 disconnecting the g-tube and connecting it to the 60cc syringe she used to put fluids into the tube. A review of the facility policy for infection control indicated: Employees must wash their hands, before and after direct contact with resident's, after removing gloves, after contact with blood, body fluids, secretions, mucous membranes, or non-intact skin.	F 442		
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure staff remove gloves and wash their hands after giving care to 3 (R11, R17, R13 and R20) of 21 in house sample residents, and 1 (R32) expanded sampled resident. Findings include: 1. Record of R11's Minimum Data Set, MDS, of 3-29-09, shows she is totally dependent on staff for hygiene and is incontinent of bowel. R11 was observed on 5-12-09 at 2:20PM, to have a Urinary Catheter and to be incontinent of bowel. R11's catheter was leaking and her incontinent brief was soiled with urine. E12, CNA was observed to removed R11's soiled incontinent brief and then wearing the same gloves, she turned on the light and went into a drawer. E12 then cleaned R11's feces from the	F 444		

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F 444	Continued From page 161 rectum and then cleaned the catheter while wearing the same soiled gloves. 2. Record review of R17's May 2009 Physician Order Sheet, POS, shows R17 has pressure sore treatments and a tube feeding. On 5-13-09 at 1:25PM, E15, Registered Nurse, was observed to reposition R17 during a skin check and then wearing the same gloves, E15, flushed R17's tube feeding and started the tube feeding. 3. Record review of R32's MDS of 4-10-09 shows he is occasionally incontinent of bladder. On 5-12-09 at 11:40AM, E12, CNA, was observed to touch R32's buttocks during a skin check and then touch his wheel chair with the same soiled gloves. 4. R13 currently has an unstageable pressure ulcer on her right heel according to the weekly pressure ulcer report sheets. On 5/13/09 at 1:26pm, Z1, Wound Specialist and E7 wound nurse entered R13's room to do the treatment/dressing change on R13's heel. R13's heel dressing had obvious drainage through the dressing. Z1 stated she had not noted that before but stated the drainage had no odor. Z1 donned gloves and removed the soiled dressing wrapping it in her gloves as she pulled them off. Z1 applied alcohol to her hands but did not wash them with soap and water. E7 then applied the ointment to R13's wound bed removing her gloves after she applied the dressing. Again, no handwashing was done but alcohol gel was used. Review of the wound report failed to show R13's wound drainage but did note a decline in the wound from a stage III to a unstageable due to her developing slough. Z1 stated the wound bed did appear a lot cleaner and a "little smaller."	F 444		

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F 444	Continued From page 162 Neither nurse was noted to wash their hands until just prior to leaving the room. 5. On 5/13/09 at 1:07pm, Z1, wound care specialist and E6, Treatment nurse entered the room to do R1's dressing change. Z1 donned a pair of gloves and removed R1's outer leg dressing wrapping it in ther gloves as she removed them. Z1 then put on a clean pair of gloves and cleansed the wound, again wrapping the soiled gauze in her gloves as she removed them. Z1 applied alcohol gel to her hands but did not wash them with soap and water. E6 then put on gloves and applied medication to the wound bed following it with a dressing. No hand washing was done until after the entire dressings had been changed to both R1's outer leg and coccyx area.	F 444		
F 465 SS=B	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide adequate storage to maintain the outside of the facility in a sanitary condition during one day of observation. Findings include: 1. On 5/13/09, at 10:42 AM, the following items were stored on the lawn in the back of the facility: six metal bed frames, two sets of handrails, 8 wooden pallets, one chair, four wheelchairs, two	F 465		

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F 465	Continued From page 163 mattresses, and two porcelain toilets. These items could be seen from windows in residents' rooms on the south side of the 200 hallway. On 5/13/09, at 10:45 AM, E42, Maintenance Director, noted there was not enough available storage at the facility. He indicated some of the items could be stored at their facilities owned by the same owner.	F 465		
F 490 SS=D	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently 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 observation, record review, and interview; the facility failed to provide adequate systems in place, and guidance to staff to assure residents reached or sustained their highest level of well-being. The facility failed to have systems in place for quality assurance and infection control. The facility failed to ensure proficiency of licensed staff, nursing and certified nursing assistants. Findings include: 1. F164: Based on observation and interview the facility failed to provide privacy during care for two (R1 and R8) of 21 sampled resident, and two (R30 and R42) off sampled residents. 2. F221: Based on observation, interview and record review, the facility failed to identify a	F 490		

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F 490	Continued From page 164 medical need and assess the risks versus benefits for the use of restraints for five (R4,R9,R15,R18 and R24) of five sampled residents with restraints. This failure resulted in R9 falling to the floor with his wheelchair and soft waist restraint attached to him. R9 sustained a laceration to his nose. He was sent to the hospital and received sutures. 3. F225: Based on observation, interview, and record review the facility failed to investigate and report to the Department, an allegation of possible physical abuse for one (R8) resident in the sample of 21 . 4. F226: Based on observation, interview, and record review the facility failed to follow it's policies to investigate an allegation of abuse for one (R8) resident in the sample of 21 . 5. F241: Based on observation, interview and record review, the facility failed to ensure residents do not have to sit for extended time before receiving their food for four (R5,R9,R16 and R17) and two expanded sampled residents (R42 and R45) during two meal observations; and failed to promote dignity of one (R31) expanded sampled exposing herself; and failed to promote dignity by maintaining clothing in good condition for two (R8 and R15) of 21 sampled residents. 6. F246: Based on observation, record review, and interview; the facility failed to answer call lights timely and have call lights accessible for three (R1, R2, R41); failed to accommodate resident preferences for awakening and bedtime for six (R5, R47, R48, R49, R50, R52, R32); failed to offer showers regularly for one (R33),	F 490		

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F 490	Continued From page 165 failed to serve meals timely to numerous dependent residents while other residents were eating; failed to remove soiled meal trays timely for one (R7); failed to provide appropriate resident equipment for one (R1, R13) of 24 sampled residents and seven off-sample residents. 7. F248: Based on observation, interview and record review, the facility staff failed to assess and provide meaningful activities for four (R2,R3,R6 and R11) of 21 sampled residents and one (R32) expanded sampled resident. 8. F250: Based on observation, interview, and record review the facility failed follow it's policies to provide sufficient social services to meet the needs of two (R8, R21) residents in the sample of 21. 9. F258: Based on record review and interview; the facility failed to address residents' complaints of noise levels. 10. F272: Based on observation, interview and record review, the facility failed to assess the for the risks versus benefits of restraints for two (R9 and R18) of five sampled residents with restraints; the facility failed to provide accurate assessments regarding pressure ulcers for two (R17 and R22) of 14 sampled residents with pressure ulcers; the facility failed to conduct inital nursing assessments for one (R23) of 24 sampled residents; the facility failed to complete the Resident Assessment Protocol for one (R4) of 24 sampled residents; failed to conduct accurate and on-going assessments for pain management for two (R9 and R18) of eight sampled residents with pain; the facility failed to	F 490		

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F 490	Continued From page 166 complete the comprehensive assessment for one (R21) of 24 sampled residents. 11. F279: Based on interview and record review the facility failed develop a comprehensive plan of care to address the needs of residents for two (R21) of 24 sampled residents. 12. F280: Based on observation, record review, and interview; the facility failed to review and revise care plans to address changes in level of care, and address new physical conditions for 7(R18, R11, R8, R13, R9, R7, R10) of 24 sampled residents. 13. F281: Based on observation, interview, and record review the facility failed for three (R36, R37, R38) off sampled residents to do accu-checks and administer insulins in a timely manner;the facility failed for one off sampled resident (R35) to ensure that accu-checks were done only at the time specified by the physician; and the facility failed to apply a splint per physician's order for one (R6) of two sampled residents with splints. 14. F286: Based on record review and interview, the facility failed to have 15 months resident assessments in the clinical record for eleven (R1, R2, R3, R5, R7, R10, R12, R13, R14, R22, R24) of twenty-four sampled residents. 15. F309: Based on observation, record review and interview, the facility failed to have an accurately assess and monitor pain management for five (R16,R13,R1,R18 and R9) of 10 sampled residents; the facility failed to follow an order for a fluid restriction for one (R7) of three sampled residents on a fluid restriction; the facility failed to	F 490		

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F 490	Continued From page 167 ensure coordination of care for two (R1, and R10) of four sampled residents receiving Hospice; the facility failed to provide coordination of care for one (R21) sampled resident receiving dialysis; the facility failed to provide accurate and individualized interim care plans for four (R14,R22,R23,R21) of 24 sampled residents. 16. F312: Based on observation and record review, the facility failed to provide adequate oral care for one (R1) of 21 sampled residents; failed to provide adequate grooming of nails and facial hair for three (R1,R6 and R9) of 21 sampled residents and one (R43) expanded sampled resident; failed to provide complete incontinent care for one (R3) of seven sampled residents who were incontinent of urine. 17. F314: Based on observation, record review and interview, the facility failed to have a system in place for pressure sore prevention, identification, assessment, and treatment for 9 (R1, R6, R7, R9, R11,R13 ,R14,R15, R17, R18, and R20) of 24 sampled residents. This failure resulted in harm to R17, who developed an avoidable facility acquired Stage 2 pressure ulcer on the coccyx that decline to a Stage 3. In addition, R17 developed an avoidable facility acquired Stage 2 pressure ulcer on the right hip. This failure resulted in harm to R7 who developed four Stage 2 avoidable facility acquired pressure ulcers that the facility failed to identify, assess and treat. This failure resulted in harm to R13, who developed a facility acquired Stage III pressure ulcer on the right heel which declined to an unstageable pressure ulcer. This failure resulted in harm to R1, who developed a Stage III pressure ulcer which increased in size and is currently an unstageable pressure ulcer.	F 490		

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F 490	Continued From page 168 This failure resulted in harm to R18, whodeveloped a facility acquired avoidable Stage III pressure ulcer to her buttocks. 18. F315: Based on observation, interview and record review, the facility failed to provide incontinent care in a manner which prevents urinary tract infections for three (R11, R20 and R15) of seven sampled residents requiring incontinent care; the facility failed to encourage and offer toileting per plan of care for two (R13 and R20) of five sampled residents on a toileting program. 19. F319. Based on observation, record review, and interview, the facility failed to provide adequate psychosocial interventions for one resident (R2) with recent history of suicide attempt in the sample of 24 residents. 20. F322: Based on observation, record review, and interview; the facility failed to provide tube feedings as ordered for one (R2) resident; failed to follow manufacture's directions for hang time for one (R11); failed to ensure proper infusion rate for one (R17); failed to follow facility's policy for flushing for one (R15), failed to provide dressing to gastrostomy sites as ordered for three (R17, R14, R15) in the sample of five residents receiving tube feedings. 21. F323: Based on observation, interview and record review, the facility failed to provide adequate supervision and progressive interventions to prevent falls for four (R9, R18, R23, R24) of 21 sampled residents. (F323) This failure resulted in the following: R23 falling, on 10/9/08, after being left unsupervised	F 490		

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F 490	Continued From page 169 on the toilet. R23 sustained a nose fracture due to this incident; R23 fell on 4/21/09 and sustained a hip fracture; and R9 fell onto the floor with his restraint attached to his wheelchair on 3/20/09 and sustained a laceration to his nose requiring sutures. (F323)The facility failed to provide adequate supervision to prevent elopement for one (R28) of eight residents in the facility with a history of wandering. The facility failed to provide safe transfer techniques for two (R10 and R15) of 10 sampled residents requiring the use of gait belts during transfers. The facility failed to provide safe hot water temperatures (from 100 degrees Fahrenheit (F) to 110 degrees F in areas accessible to residents. 22. F325: Based on observation, interview and record review, the facility failed to ensure 2 (R1, R16) of 24 residents on the sample, and 1 resident, (R34) off the sample, have individualize nutritional needs assessed and received a diet as ordered. This failure resulted in harm to R16 who had a significant weight loss of 9.3 % in 2 months and who was complaining of being hungry and begging for food. 23. F327: Based on observation, interview, and record review, the facility failed to provide adequate fluids during care and at the bedside for five (R1,R9,R13, R15 and R3) of 21 sampled residents; and the facility failed to provide complete intake and output records for two (R11 and R15) of two sampled residents with gastrostomy tubes and indwelling catheters. 24. F328: Based on observation, record review, and interview; the facility failed to provide proper	F 490		

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F 490	Continued From page 170 tracheostomy care for the only resident in the facility with a tracheostomy (R2) in the sample of 24. 25. F329: Based on observation, record review, and interview; the facility failed to assess for medical reasons for increasing agitation and confusion for one (R10) , failed to provide justification, appropriate psychiatric diagnosis, targeted behaviors, and monitoring for use of anti-psychotic medication for three (R10, R3, R20) residents in the sample of 24. This failure resulted in a two falls with significant injuries to R10 on 5/4/09 and 5/5/09; three days after antipsychotic medication (Haldol) was initiated for R10. 26. F332: Based on observation, interview and record reviews the facility failed to follow it's policies for medication administration. This error resulted in two (R25, R39) off sampled residents receiving medication at the wrong time, and one (R30) resident to receive a discontinued medication. A total of 46 opportunities were observed with a total of 4 errors. This error resulted in a medication error rate of 8.6%. 27. F334: Based on record review and interview, the facility failed to follow their Policy and Procedure to provide education and offer influenza and pneumococcal immunizations for 7(R4, R9, R8, R11, R15, R16 and R21) of 21 sampled residents.. 28. F364: Based on observation, interview and record review, the facility failed to prepare pureed food in manner which maintained the nutritive value for 13 residents in the facility receiving pureed food; and the facility failed to provide food	F 490		

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F 490	Continued From page 171 which is served at a palatable temperatures at the time of meal service during one meal observation. 29. F371: Based on observation, interview and record review, the facility failed to ensure the chlorine chemical sanitizing dishwasher was effectively sanitizing dishes, utensils, and food contact equipment during dish washing for one breakfast meal observation; the facility failed to prevent potential contamination of food-contact surfaces and cooked foods during the preparation of pureed food during one meal observation; the facility failed to store food in a manner to prevent potential contamination in the freezer, refrigerator and dry food storage; the facility staff failed to prepare food in a manner which would protect the food from potential contamination. 30. F431: Based on observation, interview and record, the facility failed to follow pharmaceutical policies regarding storge and refrigeration of medications; the facility failed to ensure the medication storage areas are maintained clean and free of food items in twoof two medication rooms; the facility failed to ensure insulins and expired medications are disgarded as necessary for seven (R37,R58,R38,R35,R32,R53,R30) expanded sampled residents; the facility failed to ensure all medications are appropriately labeled with the correct resident name for one (R7) of 21 sampled residents and one (R53) expanded sampled residents ; the facility failed to provide thermometers to ensure appropriate temperatures for refrigerators storing medications in one of two medication rooms; and the facility failed to ensure all stock and emergency medication boxes are locked and dated in two of	F 490		

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F 490	Continued From page 172 two medications rooms. 31. F441: Based on interview and record review, the facility failed to implement an infection control program to identify and monitor infections for all residents in the facility; and the facility failed to provide an aseptic technique when completing dressing changes for one (R8)of 12 sampled residents with pressure ulcers . 32. F442: Based on observation and record review the facility failed to follow it's policies for isolation for one (R15) resident with infections of C-Diff and MRSA, in the sample of 21 residents. 33. F444: Based on observation and record review, the facility failed to ensure staff remove gloves and wash their hands after giving care to 3 (R11, R17, R13 and R20) of 21 in house sample residents, and 1 (R32) expanded sampled resident. 34. F465: Based on observation and interview, the facility failed to provide adequate storage to maintain the outside of the facility in a sanitary condition during one day of observation. 35. F497: Based on record review and interview the facility failed to ensure that all Certified Nurse's Assistants have the required minimum of 12 hours per year of inservice training (E46, E47, E48, E49, E50). 36. F501: Based on record review and interview, the facilities Medical Director does not assist with the coordination and evaluation of the medical care of residents within the facility. The Medical Director is not involved in helping the facility identify, evaluate, and address health care issues	F 490		

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F 490	Continued From page 173 related to the quality of care and quality of life of residents. 37. F514: Based on record review and interview, the facility failed to maintain complete, accurate, assessible, and organized clinical records for all (R1-R24) twenty-four sampled residents. 38. F320:Based on interview and record review; the facility failed to provide a system for quality improvement and maintain a quality assessment committee with quarterly meetings.	F 490		
F 497 SS=E	483.75(e)(8) REGULAR IN-SERVICE EDUCATION The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure that all Certified Nurse's Assistants have the required minimum of 12 hours per year of inservice training (E46, E47, E48, E49, E50).	F 497		

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F 497	Continued From page 174 Findings include: 1. On 5/20/09 a review of 10 randomly selected Certified Nurses Aides (CNA) staff records were reviewed to see if they met the minimum of 12 hours per year training requirement. Five of the CNA records reviewed, E46, E47, E48, E49, and E50 failed to have the required 12 hours completed. On 5/27/09 at 10:00 AM in a phone interview, E1-Administrator stated that she was herself new in her position. E1 stated she was just recently made aware that several facility CNA's did not meet the required amount of 12 hours. E1 stated that the last month the facility had been actively trying to offer additional inservices in an effort to get the CNA's hours to meet the requirement.	F 497		
F 501 SS=D	483.75(i) MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facilities Medical Director does not assist with the coordination and evaluation of the medical care of residents within the facility. The Medical Director is not involved in helping the facility identify, evaluate, and address health care issues related to the quality of care and quality of life of residents.	F 501		

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F 501	Continued From page 175 Findings include: Record review of the facility undated Policy and Procedure for Medical Director Responsibilities reflects the purpose of the procedure is, "The facility retains a physician designated as Medical Director, to coordinate the medical care provided by attending physicians, and to assist with developmentation of resident care policies." The policy states the Medical Director serves on the facility Quality Assurance committee, and acts in behalf of the facility, when issues such as communicable disease occurs. The policy states the Medical Director will be responsible for the following: a) Implementing resident care policies: (Acute change in condition and frequent falls of a resident.) b) Coordinating Medical Care for the facility. c) The Medical Director must be informed of any new policy that has been developed and they must have input into the correctness so that it meets professional standards of care. d) The Medical Director is responsible for making sure that all the other primary doctors see their patients in a timely manner and that they provide care that meets professional medical standards and they respond in a timely manner when called. e) The Medical Director is responsible for receiving a copy of the facility survey and reading those areas that concern resident care. They will be held responsible for making sure that the care meets standards and that all of the staff is educated in doing so. They will not be required to educate, but the certainly can if they choose. f) The Medical Director should review and revise policies as necessary.	F 501		

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F 501	Continued From page 176 G) The Medical Director should sign each policy that they review, revise or assist in rewriting to show that they had a direct hand in the development process. Also the QA minutes should reflect that the Medical Director assisted in the process of evaluating the policies and procedures for the clinical needs of the residents. h) The Medical Director should review the accidents and incident policies, ancillary services (labs, radiology, pharmacy), admissions, transfers, and discharges, physician practices, responsibilities of nursing staff in assessing medical symptoms. i) The Medical Director must guide, approve, and help oversee the implementation of the policies and procedures through various means such as QA and discussion with staff. Tj) The Medica Director should also collaborate with attendings and non physician practitioners to provide policy expectations. k) The Medical Director is responsible for making sure that the attending doctor addresses the Dietician and the Pharmacist consults sot that the residents needs are being met. l) The Medical Director is responsible for making sure the attending physician adequately responds to or assesses significant symptoms reported to them by staff. m) The Medical Director directs the care the residents receive in the facility by giving guidance and direction to the staff as well as other attending physician's, when needed. The facility Medical Director Agreement of 5-1-05, that is signed by the Medical Director, states in part, that he will be will preform the following duties: - Advise the Administrator and nursing staff of the facility on the overall provision and delivery of	F 501		

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F 501	Continued From page 177 medical care and medical management of the residents of the Facility - Approving, at least annually, the facility's written policies and procedures applicable to the delivery of medical services. - Participation in reviewing and modifying, where appropriate, procedures for developing a medica care loan for each resident of the facility. - Participation in reviewing and modifying, where appropriate, protocols and procedures for responding to emergency medical situation. - Liaison with attending physicians, as and when requested. - Consultation regarding the facilities medical record system. - Monitoring and advising as to Public Health situations or conditions known to him which may have an effect on the residents of the facility. - Participation in staff meetings, staff training, and meetings of the Medical Review Committee and other similar review meetings. - Participation and in-service and other staff training and educational sessions. -Liaison and regular consultation with the Administrator and Nursing staff of the facility. E3, Assistant Director of Nursing, stated on 5-21-09 at 4:05PM, that Z6, Medical Director, comes to the facility at least 1 time a month and sometime 2 to 3 times to see his patients. E3 stated it had been awhile since she had talked to him because he comes in the evening. Z6 does not attend Quality Assurance meetings because they are in the day and he comes in the evening. E3 states the facility does not have an Infection Control Committee. E3 stated the previous Director Of Nursing was in charge of infection control and she didn't know if Z6 reviewed infection control logs. E3 stated she was not aware of Z6 doing any review of pressure sores	F 501		

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F 501	Continued From page 178 in the facility. Interview with E2, Director of Nursing on 5-21-09 at 4:15APM reflected she started working at the facility on April 6, 2009. E2 stated she had never met Z6. She had talked to him about his patient concerning a Coumadin order. E1, Administrator, stated on 5-21-09 at 4:40PM, she had been acting as Administrator at the facility since January 2009 and prior to that she was the Nurse Consultant. E2 states Z6 comes to the facility once or twice a week or once every other week to see his residents and he talks to the Nurses. He mostly comes Saturday or Sunday or in the evening. If he comes during the day, he may discuss concerns about his residents. E1 stated the facility Quality Assurance Committee has not been meeting and that Z6 will be sent a letter and what day he would be free to attend meetings. E1 stated Z6 has not attended any meetings. E1 stated she does not know if he has ever received or reviewed any information on infection control. E1 stated the facility did have concerns of the high number of pressure sores, but did not contact Z6 except to discuss care of his residents. E1 stated that she and the facility owner wrote new Policies and Procedures in September, October and November of 2008 and she is in the process of inservicing staff this month. E1 confirmed Z6 was not involved with witting the new policy and procedures and has not reviewed them. E1 confirmed the facility was now using these policy and procedures. E1 stated the facility has had deficiencies written on complaint surveys and she had not reviewed these with Z6. E1 stated that sometimes Z6 lets them know when he is coming and if it's in the evening she will leave the incident and accident log available for him to review. Z6 only gives	F 501		

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F 501	Continued From page 179 input on his residents. If there is an accident requiring a resident to go to the hospital, and the facility is unable to get ahold of that residents Physician, Z6 will give the order to send the resident to the hospital. E1 stated that the only Pharmacy and Consultant Dietitian recommendations that Z6 reviews are for his residents. E1 stated they send the recommendations to Z6's office. When asked if the above Policy and Procedure for the Medical Director Responsibilities was in effect, E1 stated she was sure the owner of the facility believes the policy is in effect. On 5-21-09, Z6's Nurse was called at 1PM with a request to talk with Z6. His Nurse stated he would not talk to the Surveyors as he was busy with patients. When asked when would be a convenient time, the Nurse stated he would not talk to the Surveyor. When asked if he would answer question by fax machine, she agreed that questions could be sent. Questions for Z6 concerning his roll as the Medical were faxed on 5-21-09 and confirmation was received from his office nurse that they had received the questions. Z6 never responded to the questions. The facility failed to ensure the Medical Director was involved in coordination of the medical care of residents or was involved in witting, reviewing and implementing policy and procedures. See F221, F309, F314, F323, F325, F441, F442, F444, F514 and F520.	F 501		
F 514 SS=C	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514		

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F 514	Continued From page 180 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain complete, accurate, assessible, and organized clinical records for all (R1-R24) twenty-four sampled residents. Findings include: 1. Charts for all twenty four sampled residents were found to be incomplete; or missing from the chart rack for numerous days. R3 was missing all Resident Assessment Protocols (RAPs). There were no Medication Administration or Treatment Administration Records (MAR, TAR) from previous months in the chart. There were no physician progress notes on his current record. 2. R2's record was not available for review on both 5/12/09 and 5/13/09 despite repeated requests by the surveyor. On 5/14/09, E2, Director of Nursing (DON), provided the chart stating she was "auditing his chart." R2's chart had no physician's order sheet to check for current physician's orders. R2 had no information from hospital stays, no discharge instructions, no consultation reports. R2 had been sent to a psychiatric unit 3/18/09 through 3/30/09, with no information available from the	F 514		

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F 514	Continued From page 181 hospital stay. R2 was admitted to the facility for skilled care after a suicide attempt. 3. R10's chart had no RAP summaries on the chart. Care plans were missing. 4. Closed records for R23, R24 had no RAPs or MDS on the chart. E30, MDS/CP Nurse, was interviewed on 5/15/09. E30 stated she had information in the computer but had not printed out MDS and Care Plans for review and signatures of responsible staff. As E30 was notified of care plans that needed revision or additions, she would present updated, revised, back-dated care plans the following day. 5. The following resident's record were incomplete and lacking information regarding their medical condition: R1,R3,R4,R5,R6,R7,R8,R9,R11,R12,R13,R14,R15,R16,R17,R18,R19,R20,R21 and R22.	F 514		
F 520 SS=F	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE 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.	F 520		

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F 520	Continued From page 182 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review; the facility failed to provide a system for quality improvement and maintain a quality assessment committee with quarterly meetings. Findings include: E1, Administrator, was interviewed on 5/20/09 at 9:10 AM. E1 stated she assumed position of Administrator approximately 10 months ago, in July 2008. E1 stated that the facility is currently holding monthly quality assurance (QA) meetings. The facility QA meetings include all department heads and discuss issues and concerns identified by the facility. E1 stated the quarterly QA meetings have not been held for "some time". E1 was unable to find minutes of the last quarterly meeting but has not attended one since she assumed her duties as administrator in July. E1 identified difficulty with medical director not attending QA meetings in the past. E1 stated that the quarterly meeting should be attended by the medical director, pharmacy, lab and x-ray, all department heads. E1 stated issues have been identified indicating additional	F 520		

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F 520	Continued From page 183 guidance was needed for the nursing department, care, and assessments. E1 stated she and the facility's owner had been reviewing policies and procedures. A new Policy and Procedure Manual has been written but not implemented. E1 stated the new program will be introduced and implemented in June. The facility's Quality Management Program was reviewed. The Program specifies the QA committee must include the Director of Nursing, a physician designated by the facility, and at least 3 other members of the facility's staff. The Program specifies the full QA committee is to meet quarterly.	F 520		