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	14G102	A. BUILDING ______ B. WING ______	C 02/13/2008

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W 339	Continued From page 26 E9, QMRP, was interviewed on 1/30/07 at approximately 1PM. She confirmed the above findings and stated she was unsure of the last time R7 received dental care and that the 3/3/06 appt. had been only a dental assessment. She stated that the nurse is responsible for making dental appts. and was unsure if one had been made for R7. E6, RN Coordinator, was interviewed on 1/30/08 at 2:45 PM. She stated that nursing is responsible for dental appointments and that at this time she was not aware of any appointments scheduled for R 1, 6, 7, 9. She confirmed the Valium orders and start dates for R9 and R7 and stated that nursing is responsible for the pre-medication.	W 339		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060h) 350.1230b)3)6) 350.1230c) 350.1230d)1)2)3) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.	W9999		

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W9999	Continued From page 27 Section 350.1060 Training and Habilitation Services h) There shall be available sufficient, appropriately qualified training and habilitation personnel, and necessary supporting staff, to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person who is a Qualified Mental Retardation Professional. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 3) Periodic reevaluation of the type, extent, and quality of services and programming. 6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. c) A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel. d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness. e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed	W9999		

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W9999	Continued From page 28 practical nurses and other supporting personnel, to carry out the various nursing service activities. f) The individual responsible for providing nursing services shall have knowledge and experience in the field of developmental disabilities. These Requirements were not met as evidenced by: Based on record review and interview it was determined the facility failed to provide adequate health care monitoring and prompt treatment for one incident of a right femur subcapital fracture (R10), when they failed to: 1) Provide continuous health care monitoring after an injury involving R10's hip. 2) Contact the physician after abnormal signs were noted by, and reported to, the nursing staff. Findings include: According to the Individual Service Plan (ISP), dated 08/28/07, R10 is a 54 year old male who has diagnoses including Severe Mental Retardation, Down's Syndrome, Hypothyroidism, Osteoarthritis, and Severe Degenerative Joint Disease of the cervical spine. R10 functions at a broad independence level of 3 years, 7 months and has an I.Q. of 32. The ISP's medical section contained the following documentation, "After a visit with the doctor in July [07], it was determined that [R10] is suffering from Alzheimer's. Staff and nursing will continue to monitor [R10's] decline..." The physical therapy section stated, "R10 was	W9999		

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W9999	Continued From page 29 re-evaluated for his physical therapy needs on 2/21/06...He is independent but slow with mobility. He has full active range of motion in his lower extremities. No physical therapy services are indicated at this time." The most current O.T. evaluation of 12/28/06 noted that R10 communicates by using "yes"/ "no" responses and points. The record lacked a more current PT / OT evaluation. This was confirmed by E8, QMRP, during an interview on 1/30/08 at 2:30 PM. The physician's order sheet (POS), dated 1/08, included an order, started on 5/25/07, for R10's use of a wheelchair for transfer to the bus / lift, and an order, started on 6/15/07, for a wheelchair for transport to the workshop. The record does not include a current PT evaluation relating to R10's change in ambulatory status. R10's mobility status documented in the nursing quarterly assessment, dated 11/07, stated that he is able to ambulate without assist, but that R10 would like to use a wheelchair. There were no mobility limitations noted. R10's fall assessment, dated 11/07, noted that there are no limitations in mobility and that he walks frequently. Review of the facility's investigation, completed 01/04/08, documented that on 12/18/07 at 4:15pm, R10 was pushed to the floor by another resident, falling onto his right hip area. E6 (RN/Coordinator) stated on the incident report, "no injuries noted" and that R10 was ambulating as usual. She also documented this information in R10's nurses' notes. According to the investigation, R10 began to resist walking as early as 12/21/07, and that X-rays, taken 12/29, 11 days after the incident, showed a right	W9999		

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W9999		W9999		

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fractured femur (hip) and a lumbar spinal compression fracture. A further MRI showed that the spinal fracture may be an old one which had recently worsened.

On the day following the injury, 12/19 at 11:00am, E6 documented in the nurses notes, "Staff state he keeps pointing to his right knee." E6 gave [Acetaminophen] for pain and noted there was no pain on palpation to right knee and thigh area.
Her 12 noon entry stated "[R10] sitting in w/c (wheelchair) smiling, no signs of pain."

Review of the physician's progress notes revealed that on 12/20/07, at 9:35 AM, R10 was examined by Z1(MD), who documented in part, "right side hurting in right hip region...no evidence of fx. (fracture) etc., [Acetaminophen] for pain."

On 12/21/07 at 7:30am E10 (LPN) documented in the nurses notes, "complaining of (c/o) pain while changing position, could not bear weight... [Rt] leg. Palpated both legs no c/o pain on palpation...ambulating with a wheelchair. [Acetaminophen] 325 mg 2 po given at 7:30am."

On 12/22/07, E11 (LPN) documented in the nurses notes, "3pm- Refuses to ambulate, incontinent of urine. Temp. 98.6 Ax. Resisting getting out of wheelchair- pulling away & yelling. Wetting self- appears apprehensive about everything."

On 12/23/07, there was no documentation in the nurses notes.

On 12/24/07, E5 (RN) charted in the nurses notes, " no c/o pain or discomfort at present time,

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refuses to ambulate today, resisting getting up. [Acetaminophen] 2 tabs given for ambulation."

The record lacked nursing notes from 12/25 to 12/27/07.

Review of the nurses' 24 report / shift to shift / communication log book contained the following documentation regarding R10:
"12/18 - [R10], another resident pushed him over...
12/21- c/o of pain upon ambulating / change of position.
12/22 - resisting getting out of chair, pulling away, yelling, wetting self, appears apprehensive about everything!
12/23 - same complaints. Refusing to get up, using wheelchair all day, yelling when asked to get up to move or bathroom.
12/27- resisting transfers and ambulating.
12/28 - Needs X-ray, lumbar spine - hips-knees-ankles.
12/29 - X-rays this weekend? 5:30 PM - admitted to hospital. Compression fracture lumbar spine and Rt. femur."

A nurse's note, dated 12/28/07 at 9:00 AM, included the following documentation, "Seen and examined E14 [physician] for resisting ambulation. Left orders and carried out for X-ray -lumbar spine, hips, knees, ankles."

Nurses notes reflect that R10 was not sent for X-rays until the following morning at 10:00am on 12/29/07, and that he had returned to the facility at 11:30am. However, that day, at 1:30pm, E14, ordered R10 back to the hospital with a diagnosis of a compression fracture of the lumbar spine and a right femoral (hip) fracture.

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W9999	Continued From page 32 The records lacked documentation that a physician was notified of R10's change of condition between 12/20 and 12/28/07. During interview on 1/29/08 at approximately 2:00PM, E6, RN, nurse coordinator, stated that she had not informed a physician of R10's injury when it occurred, but that Z1 (MD) did examine R10 on 12/20, two days after the incident. She stated that Z1 happened to be in the building seeing other residents so E6 asked him to examine R10. E6 stated that the nurses document in one of two places, the nurses' log book to communicate between shifts, or in the progress notes. She confirmed that nursing did not call the MD about R10's continual refusal to ambulate, until 12/28. E10, LPN, was interviewed on 01/30/08, at approximately 3:30 PM, and was asked if R10 had a problem with the right leg. E10 stated that he couldn't bear weight on the right leg. E10 also stated that she did not think it was related to the fall of 12/18 because R10 had recently been taken off anti-inflammatory medication and that he might be having joint inflammation. E11, LPN, was interviewed by telephone on 1/30/08 at 2:35 PM. She stated that she works part time at the facility and had worked with R10 on 12/22/07. E11 further stated she was never told that he had fallen. E11 stated that the shift report for 12/22, was that R10 had recently been taken off anti-inflammatory medication and maybe there was some inflammation. She said, "I did not call the doctor. I wasn't thinking fracture. I was not aware he had fallen. He stood up for me when I went to see him." E11 further	W9999		

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W9999	Continued From page 33 stated that the habilitation aids were telling her that R10 was getting progressively worse and had been in the wheelchair all week. E11 stated that E6, the nursing coordinator, would usually keep staff informed of resident care issues, but that E6 had been off from 12/21/07 to approximately 1/4/08. E11 stated that if E6 had been working that week, she probably would have kept the nursing staff more informed. E11 stated she did not find out that R10 had fallen until 12/29, the day his X-rays were completed. E5, RN, was interviewed on 01/30/08 at approximately 1:30 PM. She stated that the E6, nurse coordinator, had informed her of R10's injury. She stated that she works part-time and that the nurses use a 24 hour report, the log book, to keep each shift informed of any changes with the residents. She said that she had given R10 the [Acetaminophen] on 12/24 because he was not able to verbalize whether or not he was in pain and maybe it would help him walk. E5 further stated that she did not call the doctor on 12/24 because she thought R10's refusal to ambulate was a behavior. E5 also said she asked E10 (LPN) if the doctor had been called and E10 told her that the doctor already examined R10 on 12/20 and had not seen an injury. E12 (habilitation aid) was interviewed on 01/31/08, at 3:00 PM. She said that she has worked at the facility for 17 years, currently 2 days per week and is very familiar with R10. She stated that he had always been stubborn and needed motivation to walk but once you got him going he would keep moving. She also stated that he was not very verbal but he could say "no." She said that on 12/26/07, she had worked with R10 and that he became physically aggressive	W9999		

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W9999	Continued From page 34 with her, pushing her away when she tried to get him up from the toilet and that this was very unusual for him. E12 stated further that she told E13 (habilitation aid supervisor) that R10 would not get up from the toilet and there might be something wrong with him. E13 then told her that R10 had been doing that lately. E13 then assisted E12 with putting R10 on a shower chair and rolling him back to his room. E12 said that R10 would normally stand up from his chair and move to his bed, but this time he just sat there and did not move. E12 said that she did not tell the nurse on 12/26, but mentioned R10's behavior at their hab aid meeting the next day, and was then informed that he had recently fallen. E12 told surveyor that if she had known that R10 had fallen she would have looked at the situation differently. E1, Administrator, was interviewed on 1/31/08 at approximately 11:00AM. He confirmed there was a lack of staff communication and documentation regarding R10's injury and his change of condition which followed. When E1 was asked by the surveyor for a policy regarding monitoring, documentation and staff communication of medical conditions, especially in the case of an injury, he stated that at the time of the R10's fall, the facility did not have written policy and procedure in place. (A)	W9999		