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W 154	Continued From page 20 R71 did not receive his Oysco 500+D tablet; R72 did not receive Risperdal 0.25 mg; R73 did not receive his Lorazepam 0.5 mg and Namenda 10 mg tablet; R74 did not receive his Calcium Carb 600 Vit D tablet and Septra dose; and R75 did not receive his Risperdal 3mg dose. No documentation was noted within the facility's investigation identifying that there were a total of twenty three medication errors, with nine of those errors being medication omissions. E1 (Assistant Executive Director) was interviewed on 10/30/08 at 10:40 A.M. and stated, "We reviewed all of the medication errors during the investigation and terminated E14." The facility's investigation dated 09/29/08 was reviewed with E1 at this time. E1 stated, "No" when asked by the surveyor if the facility's investigation specifically identified that E14 omitted to give R76, R77, R78, R79 and R80 their medications at the 4:00 P.M. medication pass on 09/23/08. E1 also stated, "No" when asked by the surveyor if the facility's investigation specifically identified that R67, R68, R69, R70, R71, R72, R73, R74 and R75 did not receive their 4:00 P.M. medications until the 8:00 P.M. medication pass on 09/23/08.	W 154		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1230b)	W9999		

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W9999	Continued From page 21 350.1230d)1)2) 350.3240a) Section 350.1230 Nursing Services b) Residents shall be provided with nursing services in accordance with their needs. 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. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These REGULATIONS are not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement their own policy and procedures prohibiting neglect when they failed to ensure that direct care staff promptly communicated health care issues to nursing staff for post-fracture care for 1 of 1 individuals in the sample (R1) who fractured her left femur (thigh bone) on 09/02/08. As a result of this failure, on 10/02/08 R1 again sustained a fracture to her left femur. The facility failed to ensure that: 1) Direct-care staff notified nursing staff so that	W9999		

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W9999	Continued From page 22 R1 could be medically assessed after she crawled out of bed and was discovered scooting on the floor in the hallway outside of her bedroom. 2) Direct-care staff notified nursing staff to ensure that the physician was notified of this incident due to R1's non-weight bearing status. 3) Direct-care staff used safe transfer techniques for post-fracture care to prevent R1 from bearing weight on her left leg. Findings include: The facility's policy and procedure for "Abuse and Neglect" (dated revised September 2008) states that the facility, "... has a proactive approach to the prevention of abuse and neglect and believes in our mission to provide each individual with a dignified quality of life. In review of the facility's policy, the facility failed to implement their own policy and procedures prohibiting neglect when they failed to ensure that direct-care staff promptly communicated health care issues to nursing staff for post-fracture care for R1 who fractured her left femur (thigh bone) on 09/02/08. R1 again sustained a fracture to her left femur on 10/02/08. The Physician's Orders dated 09/16/08 thru 10/15/08 state that R1 is a 67 year old female who functions at a profound level of mental retardation and has diagnosis of Osteoporosis, Arthritis, and Seronegative Rheumatoid Arthritis. R1 was observed on 10/22/08 at 1:30 P.M. at a local nursing home. R1 was in bed wearing a	W9999		

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W9999	Continued From page 23 blue air splint on her left leg. This splint ran from her lower thigh to the lower part of her ankle. In reviewing R1's medical chart at the nursing facility, an Emergency Physician Record report dated 10/09/08 was noted. This report states: "Chief Complaint: Medical evaluation for nursing home placement. Context: Was discharged home from hospital to "******" (name of facility stated) and she requires more care than the untrained staff there can provide. Placement today is for short term Rehab (rehabilitation) stay and she has been accepted to a skilled nursing facility. Recent Trauma: Hx (history) of femur fracture with 1 m (millimeter) rod then a second Fx (fracture) at a screw site. Recently seen by: Z2 (Orthopedic Surgeon) ..." In reviewing R1's medical record at the facility, a "Report of Consultation" dated 09/15/08 states, "... Pt (patient) had fracture of (L) (left) femur, fixed with closed reduction internal fixation. Bone is healing on Xray... Weight bearing as tolerated." This report was signed by the physician's assistant (Z1) and countersigned by (Z2). The Physician's Order's for 09/15/08 at 4:40 P.M. states, "Disregard previous order WBAT (weight bearing and transferring), change to partial wt. (weight) bearing < (no more than) 20# (pounds). A "Report of Consultation" dated 09/22/08 identifies that R1's cast was removed and her	W9999		

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W9999	Continued From page 24 fracture had healed. The facility's Initial Investigation Form dated 10/03/08 identifies that on 10/02/08, R1 re-fractured her left leg. 1) Direct-care staff failed to notify nursing staff so that R1 could be medically assessed after she crawled out of bed and was discovered scooting on the floor in the hallway outside of her bedroom at 3:00 A.M. on 10/02/08. In reviewing the facility's Internal Review report which is dated 10/07/08, this report identifies that on 10/02/08, at 3:00 A.M., R1 was found out of bed, scooting in the hallway outside of her bedroom on the floor by E6 (direct-care / shift supervisor) and E7 (direct-care in training). This report also states that direct-staff checked R1 for injury and put her back to bed. The Summary of Evidence section of the facility's Internal Review report dated 10/07/08 identifies that E6 (direct-care / shift supervisor) had been interviewed by the facility on 10/06/08. This report states, "She (E6) states she worked as a supervisor on 10/01/08 along with OJT (On the Job Trainee E7). R1 stayed in bed and was changed in bed. They were attending to another client who needed immediate attention. They came out of that room at approximately 3:00 pm (is to be A.M.) and witnessed R1 scooting in the hall just outside her bedroom door. Her alarm did not go off. They assisted her up and called maintenance to replace battery. E6 placed 1:1 staff at her door until maintenance replaced batteries and alarm was working and R1 was asleep. She checked for any sign of injury and there was none. She states she informed the am	W9999		

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W9999	Continued From page 25	W9999		

supervisor (direct-care staff) who took over at 6:00 am to keep tabs on R1 because she was getting out of bed, but at that time she was asleep. She had no reason to think that R1 was injured at that time because of the way she moved her legs when she wanted to get out of bed."

E1 (Assistant Executive Director) was interviewed on 10/23/08 at 10:10 A.M. regarding the facility's Internal Review report dated 10/07/08. E1 stated that E6 worked the midnight shift and that R1 had been found at 3:00 A.M., not 3:00 P.M. as stated in the report.

Further review of the facility's investigation did not identify that an incident report had been completed for the 10/02/08 incident when R1 was found scooting on the floor at 3:00 A.M. .

In reviewing R1's Nurses Notes for 10/02/08, two nursing entries were made into R1's record with one being made at 12:20 P.M. and the other being made at 5:00 P.M.. No documentation was noted within either entry identifying that nursing staff had assessed R1 after she was found at 3:00 A.M. by direct-care staff, scooting on the floor.

E4 (Director of Nursing) was interviewed on 10/22/08 at 3:15 P.M. and R1's 10/02/08 Nurses Notes were reviewed with her at this time. E4 stated, "No" when asked by the surveyor if there was a nursing entry identifying that R1 had been assessed by nursing after she was found at 3:00 A.M. on 10/02/08. E4 was again interviewed on 10/30/08 at 10:40 A.M. and stated, "Nursing staff did not assess R1 because direct-care staff did not notify nursing about R1 being found scooting

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W9999	Continued From page 26 on the floor. E4 stated, "Yes" when asked by the surveyor if staff should have notified nursing staff so that R1 could have been assessed by nursing. 2) Direct-care staff failed to notify nursing staff to ensure that the physician was notified of this incident due to R1's non-weight bearing status. In reviewing R1's Nurses Notes for 10/02/08, no documentation was noted identifying that nursing staff had assessed R1 after she was found at 3:00 A.M. scooting on the floor. Additionally, no documentation was noted identifying that R1's physician had been contacted about this incident. E12 (Facility's Medical Director) was interviewed by telephone on 10/23/08 at 2:30 P.M.. E12 stated, "No, I was not aware that she had been found earlier (on 10/02/08) scooting in the floor. They should have called me." During this telephone interview, E12 stated that Z2 (Orthopedic Surgeon) has been following R1 since her September fracture. Z2 (Orthopedic Surgeon) was interviewed by telephone on 10/23/08 at 1:54 P.M. and confirmed that he had been following R1 since her September 2008 fracture. Z2 stated, "No" when asked by the surveyor if he was aware that R1 had crawled out of bed and had been found scooting on the floor on 10/02/08. Z2 stated, "I was not notified of this incident. Z2 stated, "No" when asked by the surveyor if R1 was to bear weight on her left leg. Z2 stated, "She was to have little to no pressure applied to her left leg..." 3) Direct-care staff failed to use safe transfer techniques for post fracture care to prevent R1 from bearing weight on her left leg.	W9999		

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W9999	Continued From page 27 The Summary of Evidence section of the facility's Internal Review report identifies, "2:00 - 4:00 P.M... E5 (direct-care staff) states that R1 was wet when she woke her so she changed her clothing in bed. E5 stated that she used a one person transfer to get R1 from the bed to the wheelchair She then states she took R1 to the shower and used a one person transfer to move R1 from the wheelchair to the shower chair. E5 states that when she placed R1 in the shower chair, she noticed a golf ball sized swollen area and a small bruise on the inside of the left leg. She states she alerted the nurse and then saw a bone or rod protruding near the knee. E5 states that the area enlarged in size by the time the nurse (E8) got there..." E4 (Director of Nursing) was interviewed on 10/22/08 at 3:15 P.M. and stated, "I responded to a call from E8 (Registered Nurse/RN) that she was sending R1 out and had called 911. I checked her leg and she was sitting in a shower chair in the bathroom. Her left leg was swollen in her upper thigh area. No bone or rod was observed protruding from her leg. E8 documented this incident in R1's nursing notes. The Nurses Notes for R1 dated 10/02/08 states, "5PM At approx (approximately 4 P.M. staff called me to bathroom. Res (resident) (L) leg had a knot at the (L) inner knee with 4 cm (centimeter) diam (diameter) purple discoloration, swelling through upper (L) leg noted, res not wanting to bend leg or knee, skin pale... Res sent to *** (initials of hospital) ER (Emergency Room) per ambulance for evaluation..." This entry was signed by E8 (Registered Nurse / RN).	W9999		

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W9999	Continued From page 28 In reviewing the Inservice Training record dated 09/05/08, this report identifies that direct-care staff, including E5, have been trained on safe transfer techniques and hip precautions for R1 by the physical therapist (E13). This report also identifies that R1 was to be a "two man side by side transfer." E3 (Unit Administrator) was interviewed on 10/22/08 at 3:05 P.M. and confirmed that staff had been trained to transfer R1 with two staff. E3 stated, "After we received orders for R1 not to weight bear anything over 20 pounds, staff were to continue to transfer her with two people. They had been trained on transferring her, and they were to have her pivot on her right leg when transferring." The History and Physical Examination from the hospital dated 10/02/08 states, "This is a 67 year old female who came from "**** ***" (Name of facility stated)... History of internal fixation of the left femur. Was brought into the hospital because patient complained of pain and was noted to be acting inappropriately and had tenderness on the left hip and was brought into the hospital for evaluation.... The patient was evaluated in the ER and had an x-ray done which showed left femoral midshaft fracture with internal fixation, in approximate alignment... Orthopedic surgeon will evaluate the patient...." A "Report of Consultation" dated 10/03/08, which was completed by the Orthopedic Surgeon (Z2) states, Impression: Left Femur Fracture, Status Post 1 M (millimeter) Nailing, Left Femur.	W9999		

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Plan: She fractured through the distal locking screws. This is a spiral fracture at the distal shaft which is mildly displaced.

Z2 (Orthopedic Surgeon) was interviewed by telephone on 10/23/08 at 1:54 P.M. and stated,"R1 has been seen several times regarding her fractures. She re-fractured her leg and I saw her at the hospital on 10/02/08. She (R1) sustained a spiral fracture of the left femur. She was to have little to no pressure applied to her left leg. It is possible that R1 could have caught her leg in the bed rail when she crawled out of bed. If the facility was transferring her with two people and having her pivot and bear weight on her right foot, that would be OK as long as she was not weight-bearing on the left leg. She could have sustained such a fracture (spiral) during a transfer if she was bearing weight on her left leg and turned and twisted her leg while pivoting during the transfer. R1 has diagnosis of Osteoporosis but she could not have sustained a spiral fracture from just bumping against an object. She would have to 'sharply twist' her leg to sustain such a fracture."

E1 and E2 (Assistant Executive Director and Executive Director) were interviewed by telephone on 11/07/08 at 11:45 A.M.. During this telephone interview, E1 and E2 confirmed that staff failed to implement the facility's established procedures to ensure that direct-care staff promptly communicates health care issues to nursing staff. E1 stated, "The facility has a system in place for nursing notification. All staff have been trained on this policy. If a situation occurs, staff have been instructed to call the switchboard and the switchboard operator will radio the nurse so that they can assess the